HEALTH INSURANCE IN THE SMALL GROUP MARKET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

APRIL 3, 1990

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HEALTH INSURANCE IN THE SMALL GROUP MARKET

TUESDAY, APRIL 3, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 1310-A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 15, 1990

PRESS RELEASE #22
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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WASHINGTON, D.C. 20515
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THE HONORABLE PETE STARK (D., CALIF.) CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
HEALTH INSURANCE IN THE SMALL GROUP MARKET

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance in the small group market. The hearing will be held on Tuesday, April 3, 1990, beginning at 10:00 a.m., in room 1310A Longworth House Office Building.

In announcing the hearing Chairman Stark said: "Half of the working uninsured are employees of small firms. Of the sixteen million American children without insurance, the parents of more than 40 percent work for small firms. If all Americans are to have health insurance, we must assure than the employees of small firms and their dependents are covered."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Over 62 percent of workers in firms with fewer than 25 employees do not obtain health insurance from their own jobs, while only 14.6 percent of workers in firms with 1,000 employees or more do not obtain such coverage. There are almost seven million uninsured workers in firms with fewer than 25 employees, out of 14.4 million uninsured workers.

Health care costs appear to be rising faster for small groups than for large. A survey by the National Association of Manufacturers found that 1988 health care costs for firms with fewer than 25 employees rose 33 percent -- a rate one and one-half times as high as the rate for large firms.

Various practices of the insurance industry also appear to increase the problems faced by small groups in purchasing health insurance.

The wide use of experience rating to set premiums, as opposed to community rating, increases prices to small business. Other underwriting practices which increase the difficulties of small business in purchasing insurance include exclusions of pre-existing conditions, large rate increases for firms with older workers or those in which a worker or dependent has the misfortune to contract a serious illness, segregating of workers with high risks from group rates, coverage denials, and refusals to renew insurance.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 20, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will begin its hearing on the health insurance industry, focusing today on the small group and individual market.

These hearings have been created by the health insurance's motto, "Use it and lose it," and we are here to see what we can do, and what we can learn, and to determine what the supply side of the access problem is.

Half of the working uninsured are employed, or employed by small firms. Sixty percent of the workers in firms with under 25 employees or less don't have health insurance from their own jobs.

Fifteen percent of workers in firms with over 1,000 employees don't obtain coverage from those employers.

So the statistics go on, and the number of insurance companies who drop out of the market for individual or small group policies continues. We are seeing a wider and wider use of experience rating of premiums, and medical underwriting.

We are not seeing much progress towards community rating; we are not seeing much progress towards risk pools, or other forms of coinsurance by the industry.

In the deliberations of the Pepper Commission it was almost unanimous that there is a need for reform of the health insurance system.

I am particularly encouraged by the Health Insurance Association of America, who is on record in favor of insurance reform, and there is currently pending in the Connecticut State Legislature some proposed insurance reform legislation.

I am not convinced that health insurance is the only answer to the problem of access, but it's part of the problem, and hopefully will be part of the answer.

To that end we look forward to hearing from expert witnesses today on the problems of health insurance in the small group market, and look forward to suggestions on how we can provide access to working Americans who wish to pay for it, or whose employers wish to help them pay for it, but do not yet have it available.

I'd like to not find the same solutions that we found in the auto insurance industry, where you get into a fender-bender and your next premium is higher than the cost of your car. I think there is some question, and I've raised it myself, as to whether or not we should offer Government insurance as an alternative, or as a competitive product in the market.

Before recognizing my distinguished minority member, and before introducing our first panel, I would like to welcome Erica Zeidenberg, a constituent of mine from Oakland, Calif., who has come to Washington at her own expense to testify about her company's problems with health insurance. We appreciate her presence at this hearing.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. I am delighted you have moved so quickly, following the report of the conclusions of the Pepper Commission to schedule this hearing.

Certainly, insurance reform was one of the areas in which there was general agreement, as you indicated, among the members of the Pepper Commission.

It was never, though, quite clear to me, from the discussions within the Commission, whether we could expect that insurance reform not only would increase the availability of health insurance for the small group market, but also increase its affordability, and I hope we'll get some light shed on that.

I suspect, although I certainly hope I'm wrong, that increasing the availability on the basis that was discussed by the Pepper Commission will actually make it more expensive for those who are already getting insurance, and if that be the case, then there are some other considerations we're going to have to take into account before we follow the rest of the Pepper recommendations, which are to mandate that small business pay for what, conceivably, could be a more expensive product than it is today.

So I am glad we are here to explore this further, Mr. Chairman, and look forward to hearing from the witnesses.

Chairman STARK. Thank you, Mr. Gradison.

Our first witnesses comprise a panel, Stanley B. Jones, a consultant on health care issues from Washington, D.C., and Gordon Trapnell, who is the chief economist for the American Academy of Actuaries.

If you gentlemen would like to come to the witness table. Without objection your prepared statements will appear in the record in their entirety. The committee would be happy to have you expand on your testimony, paraphrase it, or summarize it. Please enlighten and entertain us in any way you're comfortable.

Welcome to the committee.

Mr. Jones.

Mr. JONES. Thank you, Mr. Chairman.

Mr. HENDRICKS. Mr. Chairman, I'm Gary Hendricks, for the American Academy of Actuaries. Mr. Trapnell is coming from out of town, and must be having trouble, but we'll let Mr. Jones go ahead.

Chairman STARK. Having just come from out of town myself, I, too, was stuck in traffic, and I understand the problems. We will await his arrival.

If he comes make sure he comes right up to the witness table, OK?

Go ahead, sir.

STATEMENT OF STANLEY B. JONES, CONSULTANT, WASHINGTON, D.C.

Mr. JONES. Mr. Chairman, you have a brief statement from me that describes what I think are the key issues I think I can help the committee with. Let me just review it while you're thumbing through it.

I'd like to suggest that the issues that you mentioned in the announcement for the hearing, and which trouble most Americans in small business—issues of class rating, of "book rating," of medical underwriting, exclusion of preexisting conditions and of individuals from coverage—all rise out of fundamental realities in the insurance market in this country that we need to come to terms with, lest we try to reform the system by fighting our way upstream against impossible odds.

The first of those fundamental realities, is that our system of insurance lays regressively high costs on small employers and on low wage workers, especially those in some industries.

It's a sad but true fact that our system is regressive in what it requires people to pay. Employers of low income workers, and low income workers themselves, end up paying more than their colleagues.

It's more both in absolute terms and as a percentage of wages. I give an example in the testimony here if an individual policy costs around $2,000, that can amount, out of the employee's pocket, to a substantial chunk of his wages. In fact, an employee can end up paying—especially a low wage employee 16 percent of his wages, or even 26 percent of his wages, to cover the costs of health insurance for his whole family. Employees in that income group can't afford these costs. It's no wonder they often decline insurance even when the employer offers it to them.

In addition to that, the employer finds the rates quoted to him too high for the labor market in which he works. If an employer can hire employees without offering this fringe benefit he's almost obliged by the competitive market to do that.

If he chooses to offer insurance to pay these costs, and his competitors don't, he'll find himself at a disadvantage. There are enormous pressures operative to keep an employer from laying too big a burden on himself in terms of these costs.

In fact, to buy health insurance, can be equivalent to offering a 10 percent, or even as high as a 17-percent increase in wages. If his competitors aren't doing the same thing it's likely he's not going to do that.

The first fundamental force that's operative here, basically, is a labor market force. It's a reality that in the low income, and especially small group low-income, labor market, it's very difficult to afford this kind of coverage.

The second reality is that the way our insurance marketplace works, it's to the competitive advantage of an insurer to avoid high risk individuals small groups, and to exclude their worst health problems, or charge them higher premiums.

It's a competitive reality, and it's a fundamental fact of the market, that those things put the insurer in a better advantage. In fact, it's worse than that. By not doing those things, they can easily end up, by luck of the draw, with a disproportionate share of high using companies and individuals. Their premiums will rise and they will watch employers and employees leaving them for other insurers. This is an insurance market source.

Mr. Chairman, health insurance sold to employers is a blunt and clumsy system for getting health care to our people. It's most destructive forces and practices focus on small groups.

It will take fundamental restructuring of insurance in these markets to get people in small groups the insurance that we'd like them to have, and more importantly, the health care we'd like them to have.

I'd like to stop here and go to whatever questions I can help the committee with. I have never testified without an actuary to keep me honest, but I'll do my best.

[The statement of Mr. Jones follows:]

Private Health Insurance In Small Groups: Why It Doesn't Work

Testimony: House Ways & Means Committee, Subcommittee on Health
April 3, 1990

Stanley B. Jones
Health Policy Consultant

Experience-rating, class and "book-rating," medical and group underwriting, avoiding types of businesses, cost-shifting to small employers, and "free-riding" by employers and employees all contribute to the failure of our small group health insurance system. Three fundamental realities drive these practices and may prevent small-group insurance from ever working.

1. Our system of insurance lays regressively high costs on small employers and low wage workers, especially those in some industry classes. The premiums for small groups are likely to be higher than in large groups, especially small groups of low-wage earners. It is a sadly regressive system, where small employers and low-wage workers actually pay more for health insurance - and often much more in terms of percent of wages. This is a particular problem for the low-wage worker.

Small groups today often face premiums for decent health insurance of $2,000/year or more for the employee only - and 2 to 2 1/2 times that for family coverage. In most small groups, employees contribute between 20 - 50% of the premium. A low-income employee thus can pay as much as $1,000 out-of-pocket to buy insurance for himself only, and $2,000 to 2,500 to cover his entire family.

If you're earning $15,000 per year, you can pay 16% of your wages to buy health insurance for your family. At $9,500 per year, it can be 26%. And it's getting worse; premiums are going up and the employers are paying less. Is it any wonder many low wage employees opt not to cover their families, or opt out of insurance altogether - even when it is offered? They can't afford it! Indeed, most need housing, food, and shelter more than acute medical insurance - they would be foolish to buy it!

Regressive premiums also discourage small employers of lower wage workers from even offering health insurance. From the employer's perspective, even a 50 - 80% contribution to the premium for the employee only amounts to giving a 7 - 11% raise for the $15,000 employee and a 11 - 17% raise for the $9,500 employee. The employer's costs to cover the employee plus dependents would be more than double that.

The market place profoundly discourages the employer from paying these regressive premiums for low-skilled workers. Employers do not have to offer health insurance to get such employees in the labor market. Those who do will be less competitive.

More people are hurt by this than any other small group problem. If we trend forward 1986 figures, we can assume about two thirds (66%) of all uninsured employees today earn $15,000 a year; and 40% are earning less than $9,500.

Mr. Chairman, until we get decent health insurance to low wage workers and families, and small employers, for a lower per cent of their wages, the system won't work.

2. Our marketplace for selling to small groups requires health insurers to avoid high risk groups and individuals of all incomes, or exclude their worst health problems, or charge them higher premiums. It is a fundamental reality of this market.

Insuring large groups involves less risk of getting a disproportionate share of high users than insuring small groups or individuals. By the luck of the draw, or the cunning of competitors, an insurer can end up with a disproportionate share of high-risk small groups; this will force the insurer to raise premiums higher than its competitors, and watch these employers and employees go somewhere else for their insurance.

For the small employer and his employees - regardless of income - this means some will not be sold insurance, or quoted very high premiums, or told that one or more employees or their medical problems cannot be included.

Mr. Chairman, as long as insurers can get business by excluding people who need insurance most, the system will never work for small groups' employees with high cost medical problems.

3. Low-wage earners in small groups do not get the kind of care they need most from health insurance. Suppose you were raising children in the District of Columbia on $10,000 - $15,000 per year. You would probably want maternity and well-baby care, doctor's office care, counselling services, alcoholism and drug abuse treatment services, and assistance with a range of public health problems. These are the very things private insurance covers least - or imposes cost sharing for. And it will probably always be so, for a variety of technical and cost reasons. When employers do buy insurance for low-wage workers, it frequently doesn't include what they need most anyway.

Until we get people the kind of insurance and care they most need, our health care and insurance system will continue to fail.

Mr. Chairman, health insurance sold in the employer market is a blunt and clumsy system for getting health care to our people. Its most destructive forces and practices focus on the small-group market. It will take fundamental restructuring of insurance and these markets to get people in small groups the insurance, and more importantly, the health care they need.

I would be pleased to answer your questions.

Chairman STARK. Should we wait for Mr. Trapnell, or would you like to testify instead?

Mr. HENDRICKS. No, I am not an actuary; Mr. Trapnell is. I would prefer not to testify.

Chairman STARK. We'll go ahead then with Stan Jones, and we'll await Mr. Trapnell's arrival.

Mr. Gradison.

Mr. GRADISON. Mr. Jones, what are your reactions to the Pepper Commission's recommendations with regard to this issue?

Mr. JONES. That's a very broad question. Let me offer you several concerns, without trying to address the whole range of the Pepper Commission's report.

First, I think that mandating employers to purchase insurance is a tricky business. At best we are fighting our way upstream against powerful market forces.

I think the result of mandating employers is likely to be that the cost of whatever coverage the employer is obliged to buy is passed back to the employee.

In fact, I've been doing sort of an informal survey over the last several months in asking employers and economists what will happen with the burden of that new cost to the employer, and I have yet to find one who says anything except that it will find its way back onto the employee.

Maybe not right away. It may take 2 years or 3 years, and it may come about in the form of restrained wage increases, year to year, but it'll find its way back to the employee.

Not just the 20 percent, or the cost or the share of the premium that everyone assume will come back on the employee, but the entire cost.

Why? It'll happen because if an employer can hire low-wage workers without offering health insurance now, it means that market won't support these costs. After the mandate is passed, that market is likely to continue to operate the same way, and employers are likely to pass the burden of those costs back to their employees.

That's a big problem. It's, in my mind, nearly immoral to require an employee making $15,000 a year to pay $2,000 a year for insurance coverage for himself, and perhaps two and a half times that in insurance coverage for him plus his family.

Every public health worker I know would tell you they should have the income—they need housing, they need food, they need clothing more than they need acute medical insurance. And, incidentally, the acute medical insurance they get probably won't cover the things they most need by way of health services.

Now, I know that folks who talk about the mandate generally suggest we should also beef up Medicaid, offer buy-in arrangements to Medicaid, or otherwise subsidize the premium of the low-wage worker and employer. If that could be done sufficiently and surely, it addresses the problem.

My concern right now is that folks who sit in positions like yours, and their staffs, suggest that if we were to try to move legislation now, or in the next few years, we're likely to get the mandate; we're not likely to get the on-budget funding of these subsidies.

And without the on-budget subsidies, I think this is a disaster for the low wage worker. I think we're requiring them to buy something they don't need, and at a very high price.

Mr. GRADISON. What effect do you anticipate if the Pepper recommendations were put into effect, from banning medical underwriting, and requiring community rating. People say there is no mandate initially, but that the insurance market were the forum—the words in quotes—as suggested by the Pepper Commission, how would that play itself out?

Mr. JONES. Let me just touch a few pieces of that very broad question.

In addition to the population of low wage workers who find it hard to get insurance, we have a much abused population of people who have chronic illnesses in their family, or who themselves have chronic illnesses, who, as you know, find it difficult to get coverage.

They get excluded, these conditions get excluded, or the whole group is declined because it has one or two people of that sort among the employees.

If the employers were required to offer coverage and the insurance system precluded from these practices, it would be a great help to those people.

But let me go to your question of community rating. Our health insurance system has been on what I think of as a slippery slope for many decades. The industry once practiced community rating, and the effect of that was that, although health insurance was expensive, and would still be expensive, at least it would be evenly expensive to groups across the country, and one group wouldn't find itself paying 204 percent of the premium of another group.

Legislating community rating is, in fact, a step in the right direction, in that it goes well beyond saying we just are going to prevent insurers from excluding bad risks.

I think of the slippery slope as beginning at community rating, and extending down to where if a group has a few bad, high-using members, they can't get insurance at all.

Some would push us back up the slope just far enough to eliminate that set of practices that discriminate against people who have health problems. In fact, pushing that far will help folks who do have health problems, but we're not going to address the total problem until we push ourselves farther back up that slope toward community rating, to address the affordability issue for everybody.

One last comment, it's very difficult to police and enforce a community rating system. Let me give you an example.

If you tell me as an insurer that I have to community rate, it changes the whole competitive game that I have to compete in. What it means now is that my price is basically fixed, within limits that you might give me, and whether I make a profit or lose money, depends on whom I enroll.

So what you've told me is, you can't play with the price, therefore you have to be very careful about how you market your product, and whom you sign up. If you're clever enough about how you market, and how you design your benefit package, and whom you enroll, you can make a great deal of money under a community rating system, and there's an enormous pressure to do that.

If you're not so careful, you can get hurt very bad. Most analysts who have recommended return to a community rating process end up laying down regulations about what can be in the benefit package, about open seasons—and when they have to occur, and that you have to take in everybody.

They also lay down requirements on marketing and the design of brochures and materials, so that people can't be indirectly influenced or misled against their best interest. It's very difficult to regulate and police the community rating system.

For example, the Federal Employees Program attempts to regulate the marketing of insurance to its employees, and it goes a long way in that regard. It doesn't go nearly far enough—not nearly far enough to make it work.

I'm not sure community rating is a realistic idea, unless one is willing to go a lot further toward regulating insurance than so far people have suggested.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman STARK. How far up the slope? Go on about that a little further, if you would.

Mr. JONES. Go back up the slippery slope, or down the path? [Laughter.]

Chairman STARK. You just said community rating won't work. What are you talking about there?

Mr. JONES. I think you can only community rate, ideally, if you have one pool of insured people.

Chairman STARK. One pool?

Mr. JONES. One pool.

Chairman STARK. Standardizing benefits doesn't help?

Mr. JONES. It helps, it helps. There are a whole list of things you can do that will help eliminate the unfair profit and loss, but frankly the potential for risk selection is so high that I'm not sure you can regulate it out of existence. Technically, I don't think we know how to regulate it out of existence.

We haven't beaten it in the Federal Employees' System, and it's even harder to beat it in a wide community system, with hundreds of players, all advertising and marketing their own way.

I'm here to tell you, an insurer can do real well under a community rating system by the way it casts its commercials on television, by where it leaves its brochures, by the people who are pictured in the brochures, and end up with favorable selection and lower premiums.

Chairman STARK. Just like selling cigarettes, right?

Mr. JONES. That's exactly right. And it's very difficult to control. If you had one pool—if one insurer were handling all of the small groups in an area, and charging the community rate for it, you solve the problem.

But as long as you have multiple insurers competing, and success hinges heavily on how clever you are at getting better rather than worse risks at the margin, it's very difficult.

Mr. GRADISON. Mr. Chairman.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. I have wondered, too, if there isn't another factor at work. In the days when community rating was generally being used, there wasn't anywhere near as much self insurance as there

is today, and that's one thing—I'm just saying this theoretically, and would welcome your comments on it, because you're a lot closer to it than I am—but it's one thing, theoretically, to require the offering of a profit, but you're not requiring people to buy it.

That is to say, especially those groups which may, for one reason or other, find that they would save money by self insuring the basic benefits, and perhaps purchasing reinsurance just for the excess, you may force the lower cost groups out by community rating, and end up with a high cost—something like the high option Federal Blue Cross has been doing.

I mean, it hasn't done it intentionally, but it seems to be in a kind of a death spiraling, right?

Mr. JONES. That's a fair point. The reason insurers attempt to offer lower rates to groups who have lower health care costs is that those employers want those lower rates—they want them very badly, and the more health care costs have risen the stronger the demand has been.

Many employers are delighted if the best they can do is a coverage that precludes conditions for some of its employees but gets the premium down to what they can afford.

It's also true that if you push everyone back to a community rate, it's going to be higher than some employers are currently paying. You're absolutely right. And you could end up with some employers being less interested or happy in offering insurance.

There two cost problems. One is the cost problem of our health insurance generally, which on average has gotten so high that employers are resisting it more, and the other is this discriminatory cost issue between larger groups and smaller groups, especially smaller groups of low wage workers.

You're pointing up, I think, the fundamental market force that's driving this, and it's going to be hard to change it with touches and jiggles here and there.

Chairman STARK. If the committee will permit me, I'm going to pass to Mr. Trapnell, and ask Mr. Jones to remain at the table. We will get both of you into a good conversation here.

Welcome to the committee, Mr. Trapnell, and don't feel bad—the Chair was late, stuck in probably the same traffic you were.

So if you'd like to begin. Your prepared testimony will appear in the record in its entirety, and if you would summarize it we'll continue our inquiry of both of the panel members.

STATEMENT OF GORDON TRAPNELL, MEMBER, COMMITTEE ON HEALTH OF THE AMERICAN ACADEMY OF ACTUARIES AND PRESIDENT, ACTUARIAL RESEARCH CORP., ACCOMPANIED BY GARY HENDRICKS, DIRECTOR OF GOVERNMENT INFORMATION AND CHIEF ECONOMIST

Mr. TRAPNELL. There are a few points that I'd like to emphasize. The first is the nature of the risks that insurers face in offering insurance to small groups. One is the year to year fluctuation you have in claims, because some people are sick sometimes and not others.

A second is errors in forecasting the trend to higher spending for health that's been going on in this country since the beginning of the century.

A third is to predict the rate at which the basic health of a group of people will deteriorate.

A fourth is biased selection—the tendency of individuals to seek insurance when they need it, and the capacity of insurers to take only those who need it least.

Of these, I want to comment on the last two, as to how they affect small groups. In a large group of employees, the rate at which health conditions that have to be treated will appear in that group will be fairly predictable. If you have 100 employees you probably have 200 or more total persons.

But you get into small groups of people, especially under 10, and somebody develops cancer or a heart condition, and the cost of that group will soar.

Another fact of life about small groups is that you have some groups that will come in and out of the insurance market, as they need medical services, and others for which it is not clear which members of the group are bonafide. Some small groups will permit members—or even relatives, to join, depending on their need for health services. This can be called antiselection from the point of view of insurers, that a lot of people wait until they know they need insurance before they'll buy it.

To counter antiselection, insurers screen applications for existing health conditions. Although the application forms may have a lot of questions on them, the ones that really matter are the ones that ask whether the applicant has seen a doctor in the last 2 to 5 years, and if they have been in the hospital in the last 5 to 10. And if they have, they are required to sign the release form, allowing the insurer to obtain data from the medical records, and see how expensive that person will be to insure.

This is the basic technique used throughout this industry. But the facts of life are that if you carefully screen a group of employees and their dependents before insuring them, your costs in the first year will be something like 35 to 40 percent of the average cost, and the following year that will rise to about 60 percent of the average cost, and then it goes on up to numbers like 75 or 85 percent.

In other words, after you have screened the group you know that its costs will be much lower than it would be for an average group of people. But the effect of screening, or selection, will wear off over a period of years. In actuarial terminology, this is called select an ultimate experience.

Now, if you keep the insurance for a long period of time you'll get an average experience. But most small group insurance can be canceled at the end of a year. Thus the insurer can relate each group each year. Further, the most effective way possible to screen a group of individuals for purposes of setting the next year's rate is to look at their claims in the preceding year. Further they know when a new health condition has occurred in a group, and this can be used to predict when there will be a much higher cost the next year—or in the case of death, a lower cost. They can use this information to rate accordingly.

It's not fair to describe how this industry sets premium rates without noting the role that small entrepreneurs play. There's an adage in the field that "cost containment to small entrepreneurs means finding another insurer." They will shop themselves, or they will find an agent to shop for them, or they will shop among agents to see which one will bring them the plan with the lowest premium rate.

They don't understand that their protection is just for 1 year, and that they need protection against some one in their group becoming sick in that year. They need protection that will take care of that person until the illness has been cured—or the person has died.

But multiple year deals in this business are impractical because of the enormous increases in the average cost per capita of health care from year to year. No insurer in their right mind would guarantee the rate for more than a year or 2 in the future, because the cost of health care is out of control, as everybody on this committee well knows. Perhaps I should note one exception to that, the CIGNA—Allied Signal Co. case.

This tendency for entrepreneurs to shop particularly hard, and to be willing to take the lowest premium, is an important part of the way this market operates.

Let me describe some of the methods that insurers use to cope with these facts. One method, which is not as popular now as it once was, was to keep forming new multiple employer trusts. A new trust can be offered at a nice low rate, to sign up a lot of employers. They can charge a low rate because they screen all of the applications, and only take healthy groups. They also include a preexisting exclusion clause, that in case they missed existing health conditions, they still have a defense against the claim. So the claims can be very low in the first year, allowing them to cover their expenses in forming the trust, underwriting and marketing, including commissions to the agents.

By the second or third year, though, we have a phenomenon which can be called regression to the mean, as a group of people who have been screened begin to develop enough health conditions to start looking more like a normal group. We also have the end of the preexisting exclusion clause, so that all the conditions are covered.

As a result, the claim level in one of these multiple employer trust will typically jump up from year to year, and by the third or fourth year they need a very large rate increase—perhaps, 50 to 60 percent—something large enough to send all of the entrepreneurs who still have healthy groups out to look for another insurance plan. The insurer will usually oblige them by forming a new multiple employer trust.

After 5 or 6 years, the only groups left in these trusts are typically the ones that had somebody in the group that couldn't pass through an underwriting screen to get other coverage—and for whom the employer felt obligated enough to continue to cover, as opposed to, "Though luck, Charley, our new insurer refuses to cover you."

There are other rating approaches that accomplish the same thing. Probably the most standard approach in this industry is

what's called a tiered rating approach. A tiered rating approach means you have not one set of rates but 5, 10—I guess you could have an unlimited number of rate classes.

And what you do is, when you see that the experience of the group is worse than you expected, or worse than the other groups in its rating class, you move it up to a higher rate tier.

The more responsible insurers will not increase the rate too much at one time, or will limit the ratio of the rates in the highest tier to those of the lowest tier. But I've heard of examples, including one on television, in which the insurer apparently didn't have any limit on how much they would increase the rate. Some poor, small entrepreneur with about three people in his group was saying that his rates had been doubled and redoubled, from around $100 per month up to around $2,000 a month, because they were going to double that rate until he quit. Phenomena like that apparently do exist.

Another approach is what's called durational rating. This is where, the insurer offers two separate sets of rates at renewal. One, lower set is available if you can give us evidence that your group can still pass through an underwriting screen. If you can not the rate will be much higher.

But these are all reactions to the facts of life in this market, and the readiness of entrepreneurs to take their business elsewhere, to get a lower rate, even if they must pass through an underwriting screen to get it.

I should also mention that there are a number of insurers that do not play by these rules, particularly the HMO's, which I call insurers, the Blue Cross/Blue Shield plans in many States, and the insurance companies that do not specialize in the small group market. Most of these use what I would call a community rating by actuarial class system.

In other words, they will have a rate for each age and sex group, occupation, and so forth, and they will vary that rate for each health service area. Of course, Blue Cross plans are naturally concentrated by area.

But once a group is insured they always get the same set of rates. A new group gets the same set of rates as a group that's been with them for a long time.

Well, you ask, how can they do this? Some of the Blue Cross plans enroll small groups without screening. They have some advantages, particularly large discounts from the hospitals, some discounts from physicians, don't pay premium taxes, and they also don't spend anywhere near as much on selling insurance, and they have a higher persistency, so they are not constantly turning these groups over.

But the other way they manage to do this is that they lose money on it, and in some cases lots of money, because what is happening more and more, as insurers come in and offer these low cost plans to healthy groups the only groups that are left for these Blue Cross plans are the ones that can't get insurance or have high cost groups.

So what you might say is that, in many States, the Blue Cross/Blue Shield plans are actually running kind of a public pool, and subsidizing it from their hospital discounts on their large groups.

And when you project what's happening in many States, particularly the decline in the market share of Blue Cross, which means that these sources of subsidy are beginning to be reduced. I would project that these problems that I have enumerated will become much worse in the future, as Blue Cross plans in some States can no longer afford to run these subsidized pools.

Thank you.

Chairman STARK. Thank you.

[The statement of Mr. Trapnell follows:]

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVE
HEARINGS ON
HEALTH INSURANCE IN THE SMALL GROUP MARKET

TESTIMONY
BY THE
COMMITTEE ON HEALTH
AMERICAN ACADEMY OF ACTUARIES

APRIL 3, 1990

The American Academy of Actuaries is the organization designated by the actuarial profession to represent its views on public issues in the United States. The Academy's 15-member Committee on Health is made up of representatives from the entire range of health actuarial practice. The committee includes actuaries who work as consultants, are employed by insurance companies, are actuaries for government health programs and state insurance departments, and are employed by nonprofit health organizations. This testimony was prepared for the Committee on Health by committee members Gordon Trapnell, who has conducted multiple studies of small group health insurance and is president of Actuarial Research Corporation, and Harry Sutton, Jr., chief actuary, R.W. Morey, Inc. of Minneapolis, MN. The committee chairman, Edward Wojcik, actuary for the Blue Cross/Blue Shield Association, acted as the primary reviewer.

INTRODUCTION

At the request of the Subcommittee, the Academy's testimony addresses current practices in the small group health insurance market. The testimony is presented in a question and answer format. The Academy has organized the questions and answers as follows:

- Responses to questions 1 through 5 describe the basic risks insurers face in providing private health insurance, discuss how these risks differ between small and large employee groups, and answer the question "what is a small group?"

- Responses to questions 6 through 11 describe how insurance companies currently deal with the particular risks associated with small groups.

- Responses to questions 12 and 13 address whether the current system of providing insurance to small groups is efficient and whether requiring higher loss reserve ratios would improve efficiency.

- Responses to questions 14 through 15 examine the current and past practices of HMOs and the Blue Cross and Blue Shield plans and contrast these practices with those of insurance companies.

- Responses to questions 16 and 17 address pooling and reinsurance pools.

- The response to question 18 notes a number of suggestions that have been proposed by others that, upon further study, might improve the access of small employee groups to private health insurance. Although the American Academy of Actuaries has no specific recommendation, we would be happy to provide technical advice concerning the effects these and other proposed solutions would have.

HEALTH INSURANCE RISKS

Q1. What are the basic risks insurers face in providing group health insurance?

There are five primary types of risk involved in insuring groups of individuals for health insurance.

- o Year-to-year fluctuations in the volume of claims for a group.
- o Forecasting the rate of increase in the cost of medical care.
- o A deterioration over time in the health of the individuals in the group.
- o Integrity in an employment group.
- o Adverse or "biased" selection, i.e., finding that the group of individuals insured is in worse health than anticipated.

Year-to-year Fluctuations

For an individual with a given set of characteristics, the amount of actual medical expenditures can vary widely from year-to-year. Combining individuals into groups, however, brings the law of large numbers into play. Moreover, the level of fluctuation in health expenses attributable to purely statistical considerations drops very rapidly with the size of the group. For a very large group, say 5,000 employees, the random fluctuation from year-to-year in the volume of medical claims become trivial.

Forecasting Errors

The most pervasive source of risk in health insurance is the difficulty of predicting the rate of increase in the average cost per capita of health care. This risk is basically the same for all size groups.

Deterioration of Health Status

Health status deteriorates throughout each individual's lifetime, at different rates. For some there is little deterioration until a catastrophic event. The expected average cost of health care for any individual varies by the degree of decline in their basic health status.

An insurer offering health insurance for a closed group of individuals must increase the premium rate to reflect the average deterioration of the basic health status relative to the average expected on the basis of their age, sex and other characteristics. The rate of deterioration is much more predictable for a large group. Further, the impact of health deterioration will be negligible in a large employment group in which younger individuals are constantly replacing older retirees.

The rate is difficult to predict, however, for a small group of individuals. For example, if there is a birth deformity, a case of AIDS, a lingering cancer or a stroke among the members of a small group, the expected average future cost for the group may increase by several times (and by many times if the group is very small).

Integrity of the Employment Group

In writing group insurance, insurers depend on the integrity of the group insured, i.e., that it consist of all persons who are members of a group that was formed for reasons other than obtaining insurance. The principles of group insurance cannot be applied if persons can become members in response to an identified need for health care, or just those members of the group who know they need care enroll in the insurance plan.

To assure the integrity of groups, insurers will typically require that all members be bona fide employees or their dependents, that the employer pay at least 25% or 50% of the premium and that a minimum percentage participate (which may be 100% for very small groups).

Biased Selection

Some individuals seek insurance only when they develop a condition that will lead to much higher than average expenditures for health care. From the perspective of the insurer these individuals are trying to insure burning houses. Consequently, insurers must protect themselves against unhealthy persons seeking insurance only when they find out that they are ill, and against employers who seek insurance only when they expect someone important to them in their group to incur large medical expenses.
But insurers can select as well. By screening applicants, insurers can dramatically

reduce the average cost of claims for a number of years. For example, the ratio of the average cost of individuals who have been screened to those who have been insured a number of years by one insurer was as follows:

1st year:	45%
2nd year:	60%
3rd year:	75%
4th year:	85%
5th year:	92%

Actuaries refer to this phenomenon as "select" and "ultimate" rates. Select rates are those for persons who have been screened and are thus known to be in good health. The ultimate rates are for those who have been isured for a number of years. But since large proportions of those who purchase individual health insurance policies drop them within the first few years, and since more of those in poor health keep them than those in average or good health, those still insured after five years tend to be in worse than average health. For this reason, they might be referred to as "residual" rates.

The opportunities for biased selection, by both insurers and employers, vary with the size of the group insured. Employers purchasing health insurance must buy collectively for several persons. To cover one person with an expensive condition, they must cover others that are in good health. This averaging restricts an employer's capacity to select against the insurer, and the larger the group the smaller will be any advantage to the employer. An entrepreneur with a small firm may self-insure as long as everyone is healthy (perhaps with stop-loss insurance) and then seek insurance when someone in the group becomes ill.

From the perspective of the insurer, the potential cost of picking up unexpected expensive conditions is also reduced as the size of the group increases. For one thing, large groups will tend to include average proportions of persons with existing health conditions, so that the cost to cover them will be relatively predictable. For another, large employers are less aware of the proportion with existing health conditions and are willing to pay an average extra cost to have such conditions covered, so that anti-selection against the insurers in this respect is muted. In addition, prudent insurers will insist on examining claims data under any large employer's previous insurance contract before offering health insurance, and thus can set the premium rate at a level that will allow for the existing conditions in the group.

Q2. So, what are the important risks for small groups?

For small groups, insurers can protect themselves against the risks of year-to-year fluctuations and the uneven rate of health deterioration by selling enough policies for the laws of large numbers to reduce these risks to an acceptable level. Forecasting risks are a matter of the skill of the insurer and prudence in assessing the chance of error.
The major risks in insuring small groups are the integrity of the group and biased selection.

There are chronic problems in insuring small employment groups in determining who is really employed and being sure that all eligible employees are insured. Some persons, especially relatives of the owner, may be represented as employees only if they have health problems. A high turnover rate or a type of business in which it is difficult to determine employment status will exacerbate these problems. A single unhealthy person can have a very large impact on the claims of a small group. These problems occur in large groups as well, but do not have as much impact on the experience, since the claims are spread over a large number of individuals.
The most important risk, however, is biased selection, In the small group market, the rewards to careful selection of risks through rigorous screening greatly outweigh the rewards from reducing the cost of health care or administrative expenses. Insurers that select well have not had to worry much about managing care or the level of administrative expenses. Insurers with lower administrative costs and that obtain large discounts from providers have lost market share to insurers with much higher expenses and that did not offer substantial discounts from providers.

Q3. How does this differ from the situation for large groups?

The potential for year-to-year fluctuations in the cost of a group or for a more rapid than average deterioration in the average health status of the individuals in the group diminishes rapidly with the size of the group. In addition, the opportunities for anti-selection by an employer based on existing health conditions in the group become minimal.

Consequently if a group is large enough and consists of mostly the same individuals in the same locations from year to year, the cost to insure the group will not deviate much

from the average trend in health care costs in the general area. As a result, an insurer can set a fairly accurate rate for large groups with respect to all of the sources of risk noted above except for the forecast risk. This is accomplished by basing the rate to be charged in a future year on the actual experience in a base year for which complete data is available, projecting only for changes in the cost and level of utilization of services per capita in the area. Such a rate is referred to as an "experience rate."

The opportunity to nearly eliminate all sources of risk except forecast errors has led to the almost universal adoption of experience rating among health insurers as the basis for setting rates for larger groups. Most insurance companies have the technical capacity to set experience rates for large groups. Any large employer with a stable employment group can obtain competitive bids from a number of insurers that will be close to the expected cost of the group. Competition thus prevents insurers from charging any large employer a significantly higher rate. Since insurers cannot persuade any large employers to pay more than an experience rate, no insurer can long afford to offer insurance for less than an expected rate, unless they are willing and able to subsidize the resulting losses. These competitive pressures are reinforced by the general acceptance by large employers that they will pay the cost of their own claims.

Q4. What is a small group?

Most insurers consider any group with less than 25 employees to be small, and follow different underwriting and rating practices from those offered larger groups. In addition, most insurers further divide these groups into two classes, with the break between 10 and 15 employees. Some subdivide a further subclass with fewer that five employees ("baby groups"), for which practices are very similar to those for individual insurance.

Many insurers vary their underwriting requirements and rating practices between these size groups, reflecting the fact there is really a continuum of the degree of risk of anti-selection. This varies from virtually the same risk as insuring individuals in the smallest "baby" groups to a manageable level similar to that for large groups at around 25 employees.

Q5. Why 25 employees as the maximum for small groups?

Both the opportunity for the employer to benefit from anti-selection and the reward to the insurer from careful screening diminish as the size of the group increases. Insurers have found that as a practical matter the various factors enumerated above tend to change the nature of the health insurance contract from one in which rewards to selection are the critical variable to one where efficiency and service predominate at around 25 employees. In addition, most employers with more than 25employees will be unable or unwilling to take advantage of anti-selection on opportunities and the employer's prior claims experience will be adequate to warn the insurer against likely anti-selection. There is, however, a trend toward extending the maximum size for screening small groups from 25 to 50.

INSURANCE COMPANY PRACTICES TOWARD SMALL EMPLOYEE GROUPS

Q6. How can insurers protect themselves against biased selection by small employers?

Most of the insurers of small groups vary their rates by actuarial categories, i.e., by age sex, area and other characteristics that are known to be correlated with the cost of health care. But this does not provide an adequate protection against biased selection. The cost of unhealthy individuals can be many times the average cost of other persons in any actuarial category.

Consequently, insurers "underwrite," i.e., screen applicants for existing health conditions. In the current environment, insurers that screen applicants carefully, rejecting those in poor health, can charge much lower rates than those that do not. This fundamental fact -- plus rate competition -- means that any insurer that fails to screen may not be able to charge competitive rates or will have to take a loss on this coverage. The potential losses from anti-selection and the gains from careful screening drive behavior in this market.

Q7. How do insurers screen small groups?

They use a variety of methods. The primary method is to require that each member of a new group complete an individual application. These vary in length by insurer and may vary by the size of the group. But nearly all applications include a question that request the names of all the physicians that the applicants have visited in the last two to five years, and all the hospitals in which they have been confined in the last five to ten years. There is also a request to sign a release granting permission to obtain detailed data that can be used to assess the expected cost to insure the individual.

Another effective approach to screening is to make the agents (or brokers) responsible for finding groups that do not include any persons in poor health, and that will consequently have below average cost. Insurers can pay higher than average commissions and other sales related compensation to those agents that demonstrate that they can find such groups, and terminate any that fail. In fact some insurers have developed computer data bases that show the composite loss ratio of all groups referred by each agent or broker.

An alternative to careful screening is to strictly enforce the preexisting condition exclusion clause. This can provide up to two years (one year in some states) during which claims will not be paid for the treatment of existing health conditions (i.e., for which an insured sought or received medical attention prior to the issue of the policy). If not fully disclosed to the members of an employment group, and reported in the applications, the effect can be particularly unfair to those who have existing conditions since they may believe themselves to be insured when as a practical matter they are not. (For this reason, the NAIC is considering mandatory disclosure requirements.)

Q8. What role do the pre-existing exclusion clauses play?

If new groups were medically underwritten (e.g. in a manner similar to life insurance), or if detailed information was always obtained from the medical records of each member of a group applying for coverage, preexisting exclusions clauses would have little impact. But medical exams and attending physician statements are expensive, and relying on them would substantially increase the cost of insurance. Insurers thus prefer to rely on the answers obtained from applications. But this leaves the insurers vulnerable to misleading or incomplete answers, and not infrequently, untruthful ones. In insurance law, answers to questions concerning the health of an individual are considered to be "representations" (as opposed to warranties). Contracts issued on the basis of misrepresentations can be rescinded (i.e., declared void from issue and the premiums returned) for one or two years after issue (depending on state law), after which they are "incontestable."

Insurers usually discover the presence of misrepresentation when a claim is submitted soon after the issue of the policy. An insurer can react to the discovery of material misrepresentations in one of several ways. One way is to simply pay the claim, and perhaps take the instance as a factor in their decision with respect to renewal, especially the renewal rate. Another option is to deny the claim based on the preexisting condition, but continue the policy. If the facts discovered do not reflect circumstances that would have led to rejecting the group if disclosed in the application, most insurers will reject the claim but not rescind the policy. If, however, the circumstances disclosed by a claim reflect facts which if disclosed would have led to rejection of the application, then an insurer may attempt to rescind the contract.

Most insurers will not rescind a contract unless the misrepresentations are obvious and material, since the claimant may bring suit. Some groups may cancel anyway when they find that the insurer will not pay the claim.

Thus insurers need preexisting exclusion clauses to avoid the expense of medical examinations, and as a guard against misrepresentation. In addition, there are conditions that the insurers may have no way to find out about, or that are impractical to discover, e.g. an applicant that has tested HIV positive. Self supporting, voluntary health insurance for small groups would be impractical if applicants with such conditions can not be screened out.

Preexisting condition exclusion clauses, however, can be used in a manner that places insured employees in an untenable situation. An example is "time of claim underwriting." Instances have been reported in which an insurer launched a thorough investigation of all response received on an application when a claim disclosed that some individual in the group may be very expensive to insure. For example, the insurer could seek detailed information from the medical records of physicians not involved in the claim or for non-claimants. Also, as noted, the result may be to mislead members of a group to believe that they have employment based health insurance when they really do not. Some insurers will waive the preexisting condition exclusion clause for a higher

premium, especially for the larger of the small groups (i.e., 15 to 25 employees). But more detailed information may be requested from the medical records of the applicants and screened carefully for existing conditions.

Q9. What renewal guarantees do insurers give to small employers?

Most of the groups in the smallest size category (up to 10 to 15 employees depending on the insurer) are insured through Blue Cross and Blue Shield plans or multiple employer trusts formed by an insurer or an association. These trusts can be cancelled on any anniversary, but a single employer cannot be cancelled alone. Some trust agreements, however, permit all groups in a particular state to be cancelled, while others stay in force.

Most of the groups with 15 or more employees are insured directly with the insurer. Such contracts may have renewal guarantees or be cancellable on any anniversary. But the right to cancel is seldom exercised, at least by reputable insurers, except for cause. In addition, the Blue Cross and Blue Shield plans in some states are precluded by regulation from terminating coverage.

A discussion of renewal guarantees necessarily requires consideration of rate guarantees, An unrestricted right to raise premiums for a particular group can be construed as the right to cancel. (There is, however, no evidence that many insurers are using rate increases in this way.)

Q10. What renewal rate protection do insurers provide to small employers?

There are two kinds of rate protection available to small groups: the period for which current rates are guaranteed and the class of other groups that will be charged the same table of rates (i.e., by age group, sex, area, etc.). Most insurers guarantee rates for a year, but under some small group contracts rates can be raised after six months or shorter intervals.

The other type of restriction varies widely by type of arrangement and the practices of the insurers. For example, some small groups insured through a trust can only have a rate increase (i.e., a change in the table of rates) if all other groups insured in the same class receive the same rate increase. But some trusts permit different rating classes, i.e., different tables of rates, as described below.
Many of the insurance companies that specialize in small group health insurance set initial and renewal rates that reflect the sharply lower claim outlays that can be anticipated for underwritten groups during the first year or two. As a result, all insurers setting renewal rates must respond to competition from insurers that offer low rates to those renewing groups that can still pass through an underwriting screen. Some of the practices followed raise the rates offered to renewing groups that include sick individuals to a level that reflects the collective health status of the individuals in the group. These methods include:

- o Forming new METs
- o Tier rating systems
- o Select and ultimate rates

Forming New METs

One approach is to form a new multiple employer trust (MET) and offer it to employers that can pass through an underwriting screen. Since the group is screened (and there is a pre-existing exclusion clause), outlays for claims will be very low for a year or two enabling the trust to charge a low premium, at least initially.

As the effects of screening and the preexisting exclusion clause wear off, however, claims rise, and together with inflation, lead to the need for a large rate increase, e.g. 50% or more. But if rates are raised this much, many of those employers that can still pass through an underwriting screen will move to another insurer (perhaps to a new MET being offered by the same insurer). As the result of the self-selection by employers that leave, the rate increase for the remaining groups will have to be much higher. By the fourth or fifth year, only those groups that have uninsurable members (and the employer is willing to pay to keep them insured) are likely to remain, and the rates will be very high. At this point, the sponsoring insurer will not be able to sell the trust to any new groups, and the trust may be caught in an "anti-selection spiral." Since any further increase in the rates may induce some of the best of the remaining groups to leave, which will increase the average cost of those remaining, there may be no rate increase that will be adequate. Eventually, the insurer may be forced to cancel the MET, leaving some of the remaining employers without access to health insurance that will cover all the members of their groups without restrictions.

In order to retain the groups that will leave a MET as its rates rise, the sponsoring insurer may start another MET, and offer it to those groups that can "re-enter," i.e., pass through an underwriting screen.

Tier Rating Systems

Another approach is to offer relatively low rates to groups as they enroll, but review their experience each year to see if there was a loss on the group. If so, the table of age, sex, area, etc. rates for that group is raised accordingly. Typical multiples might be 125%, 150%, 200%, etc., applied to the rates in each actuarial category. Each such multiple is known as a "tier."

The responsible insurers will limit the rate of increase (e.g. to one higher tier each year) or the ultimate rates charged (i.e., the ratio of the rates for the highest tier to those for newly screened cases). But isolated examples have been found in which an insurer increased rates to whatever the average cost was expected to be given the health of the members, and rates had been doubled and redoubled.
An extreme to which tier rating can be taken is to utilize the right that insurers have to request detailed information from attending physicians to obtain full diagnostic information for claimants and to base the premium rates to be offered in the next rating period on the health conditions known to exist in the group. Computer data bases and the detailed diagnostic and procedure data captured in "managed care" systems provide the technical potential for very sophisticated re-rating algorithms.

Select and Ultimate Rate Schedules

Another approach is to offer separate sets of rates by actuarial category by duration. There may be just two rate tables, one for those in their first policy year (i.e., that have just been screened and are subject to a preexisting clause) and all other durations, or there may be separate tables of rates for those in their first, second, third, etc. policy years, with all remaining after four or five years combined for rating purposes.
Compared to tier rating on the basis of claims experience, select and ultimate rate schedules provide some additional rate protection to those groups that do not repass through an underwriting screen, since those groups that cannot leave are, in effect, all rated together. An insurer cannot raise the rates for such a collection of residual groups without restriction, since the result could be an "anti-selection spiral" in which the loss may increase the more the rate is increased.

The effect of all of these approaches is that the groups have no protection against very large rate increases if some members develop a medical condition that lasts a year or longer. Further, since illnesses will develop over the period insured, an annual rate guarantee means that on the average such expensive conditions will appear only six months before the rates can be increased (although the time required to process claims would normally produce longer delays in re-rating). Thus of the risks noted in the first section, many small groups are not protected against the financial impact of a decline in the health of the individuals in the group.

It can also be noted that of the methods described, the tier rating systems provide the least protection, especially if the ratio of the highest tier to the lowest (for new sales) is relatively high or unlimited. As noted, an extreme form of tier rating would be to charge the expected average cost to care for the specific diagnosed health conditions of the members of the group.

Q11. Why do small employers purchase insurance for which the premiums may be increased to unaffordable levels if an employee becomes seriously ill?

Most entrepreneurs purchase insurance the way they buy other supplies they use in their business. They react to the premium as they would to the price of a commodity. Many employers do not understand that if someone in their group should become very ill, that the price may suddenly go up. They also do not understand that they may not be able to find an alternative supplier at any price that will cover all of the health conditions in their group. They do not understand enough about insurance to value longer term rate stability, at least not enough to pay substantially more for it.

In addition, most small entrepreneurs are very busy and rely on insurance agents (or brokers) motivated by commissions and new business bonuses. Further, it is very difficult for an agent to explain the advantages of relative rate stability when the level of all rates is increasing by 10% to 25% per year or why the entrepreneur should not accept a lower rate if his group is currently healthy.

Underlying the problems of small group insurance is the relentless rate of increase in the cost of health care. There are many small businessmen who do not believe they can afford even the reduced "select" rates that are available only to groups that can pass an underwriting screen. It may only be feasible for some small businesses to offer insurance

at all by taking advantage of the health of their groups to get lower rates. The possibility of large, unaffordable rate increases may not be understood, or regarded as less of a problem than meeting the current payroll, rent, utilities and payroll taxes. As health care costs continue to increase, these problems will only become worse.

Many entrepreneurs react to large rate increases by seeking an alternate supplier of insurance. Agents respond by finding one. If they did not, the entrepreneur might find another agent. This tendency is so strong that there is an adage in the field that "cost containment to small entrepreneurs means finding a new insurer" (with lower premiums). And to get lower premiums, some small employers will subject their groups to underwriting, a new preexisting exclusion period. And the possibility of recission of the policy if all existing health conditions are not disclosed on the application.
From the perspective of the insurers, the willingness of many small employers to go through screening to get a lower rate means that those employers who do not choose to go through screening tend to have above average cost groups. Thus the cost to waive screening can be relatively large, and prohibitive for the smallest groups.

It is important to understand that the insurance companies are responding to the financial incentives and facts of life about this market, including the behavior of small employers. If they do not follow some version of select and ultimate rating strategy, they will not be competitive in the market place for new business in competition with insurers that offer select rates.

EFFICIENCY OF CURRENT SMALL GROUP PRACTICES

Q12. Is this an efficient way to provide insurance to small employers?

From the perspective of those small employers that can obtain coverage for their group at a lower cost because no member is yet seriously ill, the present rating practices make insurance available at a lower costs. Many might complain that an alternate system in which they were given protection against rate increases based on a deterioration of the health of their group is too expensive.

From a public policy perspective, however, the current practice is clearly inefficient. The result of these select and ultimate rating practices combined with screening new groups is that there is a constant change of insurers, with each transfer involving the expense of sales, underwriting, issuing new policies and booklets, setting up new records, etc. This produces two results that are against the public interest:

- o A very large portion of the premiums are devoted to administrative expenses as a result of the turnover of groups. The expense level of the insurers differentiating between new and renewal rates may consume a third or more of the premiums.

- o The protection provided to employers by much of the health insurance in force for small groups is limited to the year-to-year fluctuations in experience. Protection against the deterioration of the health of the members of the group is limited to a single year or less with some insurers.

A serious ramification is that many small employers do not have protection against one or more members of their groups becoming uninsurable. If this should happen, the employer may have to choose between paying unaffordably high rates or excluding the persons in question from coverage.

Q13. Would loss ratio requirements force insurers to concentrate more on reducing costs and less on insuring only healthy groups?

Not necessarily. Minimum loss ratios would tend to reduce commission rates and other expenses, but not the incentive to seek the best risks. The financial incentive to the insurer is too great for collecting a below average premium rate from a group that is projected to have a low level of claims. Competition will still reward those insurers that screen most effectively.
Further, employers will still seek and find an insurer willing to offer a lower rate for the next year. Insurers will devise ways of taking advantage of the effectiveness of screening in reducing costs. In addition, insurers can devise many strategies to avoid the impact of loss ratio requirements. A minimum loss ratio of, say from 60% to 70%, would still leave a rather inefficient type of insurance. Purely administrative functions only consume around 8% to 15% of the premiums. Sales and turnover explain most of the rest.

SOME ALTERNATIVES TO CURRENT INSURANCE COMPANY PRACTICES

Q14. Are all health insurers following rating practices that vary rates according to the health status of small groups?

Although the insurance companies that specialize in the small group market and follow the rating practices described above have been increasing their market share rapidly, there are a number of insurers that continue to offer stable rates to small groups. These include most of the insurers that do not specialize in this market.

Prior to the 1980's, most insurers offering health insurance to small groups followed a rating practice that may be called "community rates by actuarial class" (similar to "community rates by class" set by HMOs but with many more actuarial categories than permitted for Federal Qualification). These insurers would compile rates for small groups by adding up rates for the individuals in each group. The rates would vary by actuarial classes, typically including age group, sex, occupation, area, single or family employee and other characteristics. All small groups in an area received the same rates, whether new or insured for a number of years, and regardless of the health of the individuals in the group. Consequently, the rates charged to those groups that include sick individuals are not raised to reflect their higher average cost. There were also insurers, especially Blue Cross and Blue Shield plans, that offered community rates, i.e. rates that varied only by whether an employee was single or had a family.

There are a number of insurers that still offer community rates by actuarial class, especially for the larger of the small groups (e.g. those with over 15 employees). Also, in some states, the Blue Cross and Blue Shield plans are required through regulation to offer average community rates (e.g. for singles, couples, full families, etc.) Some of the same states also require open enrollments for small employers and individuals.

These Blue Cross and Blue Shield plans are essentially offering what amount to residual "pools" that provide coverage of last resort in their states for those small employers that lose out by having persons in their groups that can not pass through an underwriting screen to get into a low cost plan or that have preexisting conditions that may be excluded. Some of these plans have major competitive advantages (such as discounts from hospitals, a large concentrated market share and much lower sales costs), that provide a source of subsidy used to absorb the cost of offering insurance to small groups on an open enrollment basis. The capacity of some of these plans to continue to offer the subsidy required, however, is decreasing over time.

The average premium rates charged by insurers offering stable rates are significantly higher than those of insurers that vary rates for new and renewal policies. In recent years, many insurers, including the Blue Cross and Blue Shield plans that are not restrained by regulation, have been forced to follow suit, a trend that appears to be accelerating. The cumulative impact is likely to be increasing numbers of small employers that must choose between paying much higher than average rates or excluding some members of their groups. Also, since the loss ratios of the insurers varying renewal rates by health status tend to be lower than those that offer community rating or community rating by actuarial class, an increasing proportion of the small health insurance dollar is devoted to expenses. This exacerbates the primary problem that small firms have with health insurance, its high and rapidly increasing cost.

Q15. If the Blue Cross and Blue Shield plans are operating residual pools, is there any reason for federal intervention?

Where there is a Blue Cross and Blue Shield plan that offers open enrollment coverage to small groups, there is no need for further intervention to make sure that coverage is available. There are also a number of states that have sponsored residual pools for uninsurable individuals that also offer coverage of last resort to small employers. It is not known to what extent these pools have provided a safety net for small employers with uninsurable employees.

Nevertheless, there are many states that do not have either a state sponsored residual pool for the uninsurable or a Blue Cross and Blue Shield plan that offers open enrollment. In addition, some of the latter have lost some of the competitive advantages that permitted them to subsidize small group coverages, especially those states with "all payer" systems that limit the Blue Cross discount. In addition, some of these states require the Blue Cross and Blue Shield plans to subsidize individual and Medicare supplement coverages to such an extent that the plans are unable to provide all of the subsidies needed. Consequently there may come a time in the near future when some of these plans will have to stop subsidizing small groups.

REINSURANCE AND POOLING

Q16. Could the risks associated with small groups be mitigated by turning these into large group risks through reinsurance pools? How?

There are two basic ideas in this question: pooling small into larger groups and reinsurance. Let us discuss the latter first.

There is no fundamental difference between insurance and reinsurance. Both must operate according to the same financial forces. Reinsurance is the term applied when it is an insuring entity that obtains the insurance. In most cases this means insurers such as insurance companies or HMOs. But it can also mean individual employers. A large proportion of employers with 100 to 1,000 employees (and many larger ones) self-insure but obtain stop loss insurance to limit their risks. Many firms smaller than 100 employees also partially self-insure, with either aggregate or individual stop loss insurance. (Aggregate stop loss insurance will place a total or partial limit on the total claims that the employer must pay, with the insurer paying the excess, or some percentage of the excess. Individual stop loss insures the excess over a stop loss limit for each individual insured, e.g. $50,000 per calendar year.) Stop loss insurers face the exact same risks with small groups that basic insurers face, and react to them in the same ways.

In connection with public programs, reinsurance is often offered as a way of reducing the cost of insurance or guaranteeing access for those that insurers are unwilling to take. To reduce the cost of insurance to participating employers through the reinsurance program relative to other insurers, however, there must be either operational efficiencies or an external source subsidy.
Sharing of risks among participants can not reduce the average cost but only share the costs more evenly among participants. In a voluntary system, no employer will pay more than their own expected costs. Put another way, in a competitive, voluntary system there will be an insurer that offers each employer a premium that reflects their expected cost, given the health status of the members of the group. Thus voluntary reinsurance without a source of subsidy cannot reduce the overall cost of insurance. Further, reinsurance cannot of itself reduce administrative costs, in fact, it adds to them by creating another administrative layer. Thus, in the absence of subsidy or compulsion, a reinsurer is in the same position as any other insurer offering to insure small employers and can do no better.

In some proposals, the apparent source of subsidy is from other employers, notably those that could obtain insurance from other sources. But if they can do so they will, and consequently will not provide the source of subsidy, unless coerced to "purchase" reinsurance. In the latter case, the reinsurance premiums include a large component of taxation, i.e., the excess of reinsurance "premium" over what that employer would have to pay in a private market. In this respect they will be like social security "contributions", which of course are mandatory taxes. And if participation is voluntary, there will be no subsidy, since the employers that do not need the help will not voluntarily purchase the reinsurance.

Q17. And what about pooling?

Combining small groups into larger groups for insurance purposes does have the potential to reduce sales and administrative costs and obtain greater leverage with insurers. The key is the stability of the groups. If individual employers can join or leave the groups at will, the group will be in the same position as any insurer with respect to anti-selection and the administrative costs of issuing new booklets and maintaining enrollment files. Another way to look at it is that it is the functions that must be performed that determine the level of expense. Unless the functions are changed the overall administrative expenses will not be reduced.

There are a number of multiple insurer trusts that are based on a business association. The key to the success of the concept is the loyalty of the employers to the association. If they leave readily for a short term premium advantage, the association will have no advantages over other sources of insurance for small employers. Thus, the key to obtaining economies of scale is the stability of the combination of groups. To reduce administrative functions and to avoid anti-selection, employers cannot be constantly opting in and out.

OPTIONS FOR CONSIDERATION

Q18. Can you offer potential solutions to the problems you have outlined, that would direct competitive pressures toward reducing costs of insurance rather than insuring groups that do not have medical expenses?

Actuaries have different opinions concerning measures that need to be taken in response to the situation described. The Academy has not prepared specific recommendations. Some of the measures that have been proposed by others include the following:

- Require that small group insurance policies be guaranteed renewable and that insurers charge the same rates, for each actuarial class, to new and renewing policies with similar benefits (i.e., community rating by actuarial class), with the rating classes including all significant actuarial variables except health status.
- Require all insurers to offer at most one policy form in each of several pre-designated categories of benefit packages (e.g. high option, low option, catastrophic, etc.) and follow community rating by actuarial class for all groups in each category.
- Restrict the variation in the rates for any actuarial category to no more than double the lowest rate offered for similar benefits.
- Restrict annual rate increases to forecasts of the trend in health care costs per capita.
- Prohibit "at-time-of-claim underwriting."
- Require full disclosure of the potential for a preexisting exclusion clause to restrict coverage when employers change insurers.
- Require open enrollment for any new employees or dependents joining a group where the motivation was not to obtain insurance and at least for all persons previously covered by an employer plan.
- Require open enrollment among all insurers to employers that have previously been insured.
- Limit insurers through a pre-enrollment competition.
- Limit or prohibit sales commissions and bonuses (e.g. as in federal procurement regulations).
- Subsidized pools for uninsurable groups or members of small groups.

Actuaries with extensive experience in small group health insurance believe that each of these measures would have ramifications that are not fully understood and that need to be analyzed in the full context of any legislative proposal. Further, the impact of each of these measures may be quite different in the context of an employer mandate to offer a minimum plan. We also believe that because of the diversity in the characteristics of small groups, no single measure is likely to solve all of the problems in this market. In fact the difficulties presented by this market are so complex that it is likely that any legislation will create new and unforseen problems. The Academy is particularly interested in assisting you in identifying as many of these as possible in advance so that legislation will take them into account.

We will be happy to discuss the implications of each of these possible measures with the committee or its staff or to submit more material for the record, together with the extent to which various options may help solve the problems presented above and the side effects the options may involve.

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Chairman STARK. I'm going to ask the committee now to inquire of both of you as witnesses.

Mr. Cardin, I think we will let you start.

Mr. CARDIN. Thank you, Mr. Chairman.

I want to thank both Mr. Trapnell and Mr. Jones for their testimony.

I have really been fascinated by your analysis here, Mr. Trapnell. It seems to me that when I buy life insurance, and even if I don't buy on a group plan, I can get a fairly competitive rate because the life insurance market is doing their actuarial projections based upon my age, and based upon a much broader class—basically, as you put it, community rating, I guess, by classes as Blue Cross/Blue Shield does.

I wonder why there isn't a very simple solution to this problem. That is, expand on the Pepper Commission's recommendations and prohibit the type of insurance practices that cause the small group plans to fluctuate by such great numbers every year, and also cause people who are high risk to have very real options as to where they can get their insurance, who have, because of the individual rating or the preexisting conditions been excluded.

So if the Congress were to consider legislation that would prevent the preexisting condition from being excluded, or were to require some type of a community based rating system, if I run retail sales and had 25 employees, I could buy a plan of health insurance that was based upon a large number of groups of employers that were in retail sales in the general area in which I am an employer. That group would of large enough numbers, it seems to me, to meet the criteria that you have established for a large group. Wouldn't that eliminate a lot of the problems for smaller employers?

Mr. TRAPNELL. You would eliminate some problems, and find yourself with a lot of others. For example, many groups, even down to 10 and 15 people will self insure, and they can do it two ways. One is that they can actually self insure. Another is that they can purchase what's known as aggregate stop loss insurance.

In other words, instead of the kind of health insurance that you are familiar with, they can purchase insurance that says, well, you're responsible for the first $25,000 of claims, and we'll pay 80 percent of the excess of that.

Many small employers will take that if they've got healthy groups, but more important is that many will decide to seek insurance, and not seek insurance, depending on what's best for them that year.

And whatever the reforms that are introduced, you have to take those facts of life into account.

For example, if you mandated that all small employers, in protecting some clients, purchase insurance, then you can create a stable market. But you still have some problems, because you've got to give the insurers real groups. You can't let small entrepreneurs add Aunt Sarah or Uncle Jake, who suddenly turns up as an employee when they need expensive medical care.

Mr. CARDIN. Well, it seems that there are two parts to the Pepper Commission's recommendations. One was to enact insur-

ance reform—medical insurance reform—and the second is to require insurance coverage one way or the other.

Mr. TRAPNELL. Yes.

Mr. CARDIN. So if both of those were carried forward, wouldn't that solve a lot of the problems that you have mentioned?

Mr. TRAPNELL. Mandate that everyone has to have health insurance, and they have to buy it from an approved carrier that must meet whatever regulatory rules that you're setting up in reforming the marketplace; these go a long way to solving some of those problems.

There are reforms that you can introduce without mandating insurance that I also think would help improve the way this market works.

Mr. CARDIN. Such as?

Mr. TRAPNELL. In particular to require that insurers offer guaranteed renewable insurance, and that they follow a form of community rating by actuarial class, and, in other words, that an employer whom they sell insurance to this year gets the same rates by actuarial class as the employers who have been insured in that class for 5 or 10 years. Prevent them from adjusting rates based on changes in the health of an employment group.

Mr. CARDIN. When you say community rating by class——

Mr. TRAPNELL. Community rating by actuarial class simply means that you establish a lot actuarial categories and have the same rate in each one. It's like community rating by class in HMO regulation.

Mr. CARDIN. I see. Now, I also understand the difference between that and what you were saying about preventing insurance companies from changing the rate from year to year, plus there was an experience among other——

Mr. TRAPNELL. Well, the rates were changed. In any kind of health insurance you have rates that are going to be changing every year, because of the basic fact of life of health inflation.

Mr. CARDIN. It seems to me what you're trying to get at is preventing an insurance company from taking a group of three people, or a small group, and saying because their experience in 1 year was poor we're going to increase their rates by 100 percent, but rather say that there is justification in the characteristics of that group that is common to all groups of similar characteristics, and then you can increase the rates, by whatever percentage the risk factors have gone up.

Mr. TRAPNELL. You say it much better that I could have.

Mr. CARDIN. Thank you. [Laughter.]

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

My concern about community rating is that, at least as I understand it, it would prohibit us from rate differentials serving as incentives for lifestyle changes. For example, I don't want us to lose the ability to offer lower cost health insurance to people who don't smoke.

I'd like to get to where we could find some way to demonstrate whether or not you've used illegal or harmful substances, because the evidence is so absolutely overwhelming that it's much cheaper to buy health care for people whose lifestyles support wellness, and

I would not want us to see us move to a system at this time that tied our hands in regard to a leveraging of wellness behavior, because that will do more about health care costs than we can ever do from PROs and oversight, and all that stuff.

And yet listening to you, and reading in the past about some of the reforms recommended, I don't see that some of the reforms we want to see in the health care insurance industry are incompatible with community rates that might be allowed to fluctuate, at least according to things that would affect health.

I don't see why that would be incompatible with saying that you couldn't exclude preexisting conditions, that you could not insure a group the following year.

In other words, if you require an insurer you deny them the right to select, and you say it must be renewable, then they're going to move toward different rates. There's not going to be this differential between the selective low rate and the ultimate high rate, as you described earlier, Mr. Trapnell.

So, if you put constraints on them that mean that they can't afford to do that, because they're not going to have it below, and they're not going to be able to escape the high, then you get the benefit of greater rate consistency without denying companies the right, to compete by encouraging managed care, wellness behavior, and lifestyle patterns that are pro-health care.

Are those two things inconsistent? Wouldn't we get rate leveling through some of those reforms without having to go to community rating?

Mr. TRAPNELL. I think your example of smoker/nonsmoker rates are excellent examples of classes that should be included in any community rating by actuarial class system.

Mrs. JOHNSON. So you could do the reforms, and still allow insurance companies to set premiums with health considerations in mind. Is that within or without the community rate system?

Mr. TRAPNELL. I would like to make a very strong distinction between community rating and community rating by actuarial class. They're really entirely different things, because the community rating as advocated by the Pepper Commission would mean—I'm not sure exactly what they mean, because they weren't that exact—but I would assume that they mean that over a wide area of the country you would have one rate for single employees and a family rate, and everyone who had insurance would pay those rates, period.

Mrs. JOHNSON. So, in other words, you're not advocating——

Mr. TRAPNELL. I'm not advocating anything like that. I'm saying that what I'm advocating is that insurance companies be permitted to establish actuarial classes, based on their data, their knowledge, and, within limits, their actuarial intuition as to what matters and doesn't matter about establishing what you might call the expected costs of an individual.

You know, given this person, in the exact same shape—his habits, his occupation, everything else you know about him—on the average, what are people like that going to cost the next year?

This is the type of rating system that would emerge. But the principal application would be that, once you've established an actuarial class, everybody within that class should get the same rate.

Mrs. JOHNSON. Right. So there would be greater consistency of rates?

Mr. TRAPNELL. Yes.

Mrs. JOHNSON. And less fluctuation?

Mr. TRAPNELL. Yes, I think so.

Mrs. JOHNSON. And the reforms, of not allowing selecting and things like that, would, in your mind, be good reforms?

Mr. TRAPNELL. I think that unless you mandate that everyone have insurance, it's difficult—I'd like to separate the issue of community rating by actuarial class and other renewal rating problems, from the problems of underwriting or screening of new applications, and the preexisting exclusion clause.

The last two are related but a separate issue, and have more to do with whether you're going to present the insurers with a stable market. In other words, if you mandate insurance so that all employers have to buy from somebody, the insurers can average out the—you know, you don't have the phenomenon that employers are seeking insurance when they need it, adding members to their groups when they need it, and so forth.

Mrs. JOHNSON. So in a sense what you're saying is that, grossly, you have the same universe? Regardless of who is insuring, you're assured the same universe.

Mr. TRAPNELL. If the insurance companies are just exchanging the groups, because everyone has insurance, there is less risk to the insurers from an open enrollment. There are still a lot of problems that have to be accommodated.

There are a lot of employment groups in this country where it's very difficult to determine whether people are really employed or not, and if left to the employers, groups, some will claim that a person is employed when they need health care, and not otherwise, when they have to pay the premium.

Mrs. JOHNSON. Thank you.

Mr. TRAPNELL. And you have to deal with those questions. On the preexisting exclusion clause, which is a different type of phenomenon, there is an excellent reason for having a preexisting exclusion clause, which is that people will lie on the applications, and if insurers rely on the application and then find that the information wasn't correct, and they have insured somebody they would not have intended to insure, it gives them a defense.

The problem with preexisting exclusion clauses is that they can be abused. For example, insurer can ask, "Why should I verify the information on the application?" It's cheaper not to bother with it unless I get a claim. Then I'll investigate, find out whether it was truthful, and deny the claim, and perhaps rescind the policy, if it wasn't.

And human nature being what it is, that tends to leave a lot of people thinking they have insurance when they don't.

Mrs. JOHNSON. Yes, Mr. Jones.

Mr. JONES. Just to add a thought, because of your concern with preventive health measures and lifestyles. I'd offer the generalization, and Gordon can comment on it, that the ability of the industry at present to vary your premium as an employer, based on how healthy a lifestyle your employees lead, is so questionable and so limited, because of actuarial and other considerations, that it's

dwarfed by the question of whether you have an employee who has cancer.

And right now the market is strongly influenced by who you already have on board, and believe me, if smoking or other lifestyle practices were clearly indicative of higher costs next year, they'd be in the screening. Insurers would say, we don't want that person, and we won't insure your group if you keep that person. It's an unfortunate technical reality in the system.

It's a good idea, but I don't think the industry can do it right now.

Mrs. JOHNSON. Well, I appreciate your comment, but I think that in the future we must find ways to take those things into account. Because I don't think it's being done. It means that we can build a system that would prevent it from developing, because in the long run I think it will have more effect than others.

Also, I think we may be able to find some way of factoring in the fact that while smoking doesn't increase your cost next year, it increases the Government's costs after you're 65 without question, and we may find a way to have that reflected.

So my concern about community ratings—at least as they are proposed by the Pepper Commission—is that they are too broad a brush, and reduce our ability to "incentivize" society in a way that I think is important.

Thank you for your comments.

Mr. TRAPNELL. Can I add a little something to that? And that is that there's not much incentive to insurers to screen for smokers now because, at the end of the year, they're going to be able to totally change the rate anyway, and if the person, as a result of being a smoker, should develop a condition during that year, they'll reflect that in the next year's rates.

But under a community rating by class system they would have to screen for smokers, because now they have to worry about what the long range cost of that individual is going to be, as well as what the cost is going to be for the next year or two.

Mr. GRADISON. Mr. Chairman.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. I'd just like to follow up with Mr. Trapnell on one particular point. We do not have the small print yet from the Pepper Commission, but I believe that what they've been talking about would not permit a variation in the rate that was offered. It would be a single community rate.

If I'm wrong we'll find out when the final report come out in a month or two.

You have recommended, however, and I have your statement in front of me, to restrict the variation in the rates for any actuarial category to no more than double the lowest rate offered for similar benefits. There would be a band.

Mr. TRAPNELL. That's an option.

Mr. GRADISON. That's an option.

Mr. TRAPNELL. The band could be zero or 100 percent.

Mr. GRADISON. I appreciate that, but that's what I wanted to ask you to comment on. What do you see as the advantages and disadvantages of the option which you mentioned, of permitting a band

of up to a factor of two, versus having no band at all, which I think is where Pepper's going to end up?

Mr. TRAPNELL. Caution. Having a band of 100 percent is a radical change from the way the market works now; having a band of zero—that is, everybody gets the exact same rate—is an even more radical reform.

So, if you were cautious, and decided to reform only part way, to see if that worked, or how it worked, and what the problems with it were before making further adjustment, you might want an intermediate step.

I will also note that that seems to be what the HIAA is recommending.

Mr. GRADISON. I have also met with some of the representatives of State insurance commissioners, and on that point my understanding was that they were suggesting somewhere between 50 percent and 100 percent above the base as the way to go, at least initially.

Thank you very much.

Thanks, Mr. Chairman.

Chairman STARK. You've been talking about the anticipated behavior of employers and insurance companies. Is the anticipated behavior of individual employees diminished in this?

What I'm wondering is, is there much that the individual employee can do to game the system? Is it possible to not have insurance until deciding to become pregnant, then suddenly run and sign up? Is that a problem, or can we consider that as minor in this discussion?

Mr. JONES. You cannot consider that as minor.

Chairman STARK. All right. Define it for me then.

Mr. JONES. The employee has a number of options. For one, let's take the group that I've focused on, the lower wage worker.

If his employer offers insurance, it's likely to require him to pay a substantial amount of the premium out of pocket. He has a number of options he can exercise. One, he can insure his whole family—that'll be a lot more expensive.

Two, he can simply say, I'll take individual or self-only coverage. By this action he will add to the number of uninsured dependents who show in the statistics as having an employed relative—it's a lot cheaper for him.

Or, three, in some cases, he can opt not to have the insurance.

Another option he has, and this goes for the employer as well as the employee, is to add himself as a dependent to his spouse's policy with another employer.

Chairman STARK. OK, but what does this do? What's the actuarial cost of this? I can see the cost to the insurance industry, perhaps, of employers trying to shop constantly, but what you just described, Stanley, is what I would have anticipated.

But the low paid employee can't anticipate when he's going to get sick, and once his wife gets sick, if he doesn't insure his dependents, he can't just buy it in the next year. She's already sick, it's too late.

What I'm asking is, is there a huge cost to doing this, and do we have to regulate the behavior of——

Mr. JONES. The employee.

Chairman STARK [continuing]. The individual employee, or is that random enough so that it is not a major cost impact on the system?

Mr. JONES. Let me give Gordon a minute to think about that from the cost standpoint. Bear in mind that 60 percent of the employed but uninsured are earning around $15,000 per year, or less, about 40 percent earn $11,500 or less.

If they have dependents, they may be talking about 25 percent of their take home wages to buy health insurance for the whole family.

In fact, if the economists are right, and it's all passed back to them, it could be even higher than that. They'd be fools to take the insurance. They'd be fools to take the insurance. They ought to take the money and improve their living conditions generally, public health experts would tell them to do that.

But, the question you're asking is, does the fact that many opt not to buy——

Chairman STARK. They're also fools not to insulate their homes, although the return on the investment could be very high, and so they're not very economical in their decisionmaking.

Mr. JONES. Well, they're also, unfortunately, constrained to worry first about next month, next week, next 6 months, rather than a 1-year, 2-year or 5-year perspective in their decisions.

Chairman STARK. But in terms of how their decisionmaking influences rating, and I think it really does, do you want to touch that?

Mr. TRAPNELL. I think a lot of it depends on the nature of the group. In groups that consist mostly of low paid workers, insurance companies will have more problems for the simple reason that the money is more important to them, and they will take advantage of the selection opportunities that they have.

In high paid groups, insurance is taken for granted as a basic necessity, and they're going to buy it, and they'll get it through the employer, and this leads to a stability in the people who are covered.

But many small groups don't have the money, as Stan has been pointing out, and so they will take advantage of whatever opportunities they have to a far greater extent. Now whether——

Chairman STARK. What I'm hearing you say, then, is that if it is a problem it's a problem for low income workers. Do you want to quantify that?

Mr. TRAPNELL. Well, the rate at which health care costs keep rising, it's a moving target.

Chairman STARK. OK. The other question for Mr. Trapnell is, can you create for me in a minute or two a safe harbor? Let me just give you an idea of what I'm looking for.

Can you tell me that if I move into a community of 200,000 people, that an actuary could find a number—say 5,000 people, the number of employees—where you would feel comfortable that my adverse selection is no worse than anybody else's?

In other words, is there a large number of people, where I will be no differently impacted than a major insurer who has big groups of people?

Could you say that we should have a limit to how big the group has to be, and once you get above x number you're home free?

Mr. TRAPNELL. Let me go back over those four types of risk. The risk of fluctuation really doesn't disappear until you've got thousands of employees.

Chairman STARK. How many thousands?

Mr. TRAPNELL. Certainly 5,000 does it.

Chairman STARK. OK, if I had 5,000 people in a pool, but they were just 5,000 residents of a community, would that apply as well?

Mr. TRAPNELL. Well, if you can guarantee the insurer that all 5,000 are going to seek insurance, he can predict a rate for them. It's the stability of the group that matters there.

Chairman STARK. OK.

Mr. TRAPNELL. In other words—let me take them one by one. The risk of fluctuations diminishes very rapidly by size, and starts becoming controllable when you have as few as 250 or 500 employees. You can usually double the number employees to get the number of people involved. This gives you an idea of why it becomes stable.

But this is a statistical phenomenon that you can simulate very well by just looking at the distribution of health claims, if you know what individuals you have, and what their health is.

Chairman STARK. Right.

Mr. TRAPNELL. The second kind of risk I talked about, forecasting—of course, the Congress has as much trouble with that as health insurers.

The third type, how rapidly the health status of the group will deteriorate, again you can get very different rates, but as few as 25 or 50 employees will usually give you protection for 1 year against that.

But the most important one is the biased selection. This depends primarily on the size of the decision unit. It is sometimes advocated to get the economies of scale, small groups, should be combined into large groups. Well, that doesn't do any good if each small group is making its own decision as to whether to join the larger group or not, because then the large group that you thought you had pooled has the same problems any other insurer does.

Chairman STARK. So you're saying that at least the city has to mandate health insurance for every resident of the city?

Mr. TRAPNELL. Yes.

Chairman STARK. Or the county?

Mr. TRAPNELL. An insurer would be delighted to give you a rate for the entire city if they knew the rate at which people were going to move in and move out.

Chairman STARK. So what you're saying, in each of these cases, for fluctuation or deterioration, as long as you didn't let each individual member of the group make that decision, you'd be OK.

Mr. TRAPNELL. Right. The way they usually say it in insurance is that you can insure an association of individuals if their primary reason for joining the association was not to seek insurance. Then you can treat it as a real group, and that is, not underwrite individuals, but assume that it will have a normal distribution——

Chairman STARK. Something like being a resident of the United States, for example. [Laughter.]

Mr. JONES. That would work. [Laughter.]

Chairman STARK. Mr. Levin, would you like to join in this?

Mr. LEVIN. Well, let me just ask you a bottom line question. Is this system fixable?

Mr. TRAPNELL. That's a policy question, not a technical question, so I'll give it to Stan.

Mr. JONES. Actuaries always fade——

Chairman STARK. We do that, too. [Laughter.]

Mr. LEVIN. I'm just curious, with all your experience, and reading your testimony, and hearing the back and forth with you and the chairman and the ranking member, and Mrs. Johnson, can we make this system—this multiple, diversified system work?

Mr. JONES. I think if you got the most thoughtful folks from the different sectors of this industry at the table and asked them that question, they would all have to honestly say they're worried about that.

We're talking about this small group market for health insurance. The core of the problem is the one that we're getting close to. If you want everybody to buy insurance, and you tell them they have to, then you've got a problem of, how to make it affordable for them.

Because if you tell them that they've got to be in, if you mandate it, now you're really got a responsibility to make it affordable. So we start talking about class and community rating and the issues associated with it. Well, it's not clear those steps will make it affordable. The truth is, that the outline that Gordon just described could still end up with huge premium variations, so that one employer is paying twice as much as another.

Is that affordable?

The reason it's that way is the competition in the industry—competition among insurers for the employers' business, and competition between employers to sell whatever goods or services they are producing, and to hire help and people for as little as they can within their labor markets in order to be competitive.

It's going to be tough to fix that. I'm not sure it's fixable. I'm not sure, without going to one pool, or several very tightly controlled pools, we can ever make it affordable enough so that we in good conscience can mandate employers and employees to buy health insurance.

My compromise is to say, mandate the employer to offer it, but don't mandate the employee to buy it.

Unless we can make it affordable, you shouldn't force a low income person buy it, but on the other hand, you should make it available to someone whose kid has a chronic illness, and whose employer isn't even offering it to him.

For now, this is the only median way. We're going to find out in the next 5 or 10 years whether we can fix small group insurance or not. I think it's up for grabs.

Mrs. JOHNSON. Mr. Chairman, could I follow up on that?

Chairman STARK. Certainly. I'm sorry, if the gentleman has concluded.

Mr. LEVIN. No, no, please.

Mrs. JOHNSON. I'm very interested that you don't mention what it is that we're trying to insure, in discussing the affordability. We

have been going through this stuff in Connecticut, and in the course of our commission's work found that we could—now, Connecticut is a very, very high mandate State.

I mean, insurance is very expensive in Connecticut partly because of the enormous number of mandates that our State legislature has adopted.

But we found there was a decent program out there that we could sell for 50 percent of the premiums. So I don't think you can separate whether this can ever be made to work from the question of, what is it that is essential for people to have access to?

Because if what they're going to have access to is Connecticut-type program with all its mandates, it's going to be unaffordable, and then you can't mandate it in individual plans.

But I was stunned by the variety of programs that the Connecticut group came up with, and the variety of premiums and options that are really out there. You certainly would concur with that as an option in dealing with affordability, would you not?

Mr. JONES. Well, one of the ways that insurers are dealing with affordability in small groups today is to vastly increase their deductibles—to as much as $1,000.

That's one way to make it more affordable. It greatly reduces the premium. Others are trimming out benefits that many members want. You can keep on that track until we insure very little, but you can get the cost down.

Mrs. JOHNSON. Well, that's certainly one alternative, and Dukakis' plan has, and it's something that we weren't aware of even in Connecticut for a quite a while, a $2,000 deductible. What he's trying to get out there for everyone is a $2,000 deductible.

But what I was referring to was really a much lower premium. Yes, not everything's available to you—much more limited counseling, much more limited some other things, but I think to try to separate the product you're trying to provide from the cost of that product would be unwise, in answering the question, is the system ultimately working?

Chairman STARK. Far be it for me to resuscitate a dead horse, but I think in fairness to the good governor, his $2,000 deductible is paid by the State for low income people. What you are saying is that if you're wealthy you have to pay the first $2,000, but poor people in Massachusetts have that $2,000 paid by the State.

Mrs. JOHNSON. Oh, thank you, good.

Chairman STARK. It's not as limiting as it might be, but it certainly keeps the cost down.

Mrs. JOHNSON. And I don't know where he draws the line, as to who can afford the $2,000.

Chairman STARK. I don't know that either.

I want to thank both of the witnesses, and I hope we can hear more from both of you as we struggle with this. It's the Chair's sense that there is some movement across the country for somebody to act in this area although it's complex, and I hope that as we're pressured to do something we can continue to receive your advice on the results that might come from the various options before us.

Thank you both, very much.

Mr. JONES. Thank you, Mr. Chairman.

Mr. TRAPNELL. Thank you, Mr. Chairman.

Chairman STARK. Our next witnesses are a panel. They consist of Erica Zeidenberg, the vice president of Soft Press from Oakland, Calif.; and Fred Nagel, representing the United States Chamber of Commerce, who also is the owner of Fantastic Sam's, in Tampa, Fla., accompanied by Cindy Nagel; and Mr. Karl Hansen, who is the president of Vita Insurance Association of Mountain View, Calif., speaking on behalf of the National Association of Life Underwriters.

I'd like to welcome the witnesses to the committee. I'm going to ask the witnesses if they can try and limit themselves to 5 minutes of expanding on their prepared testimony, and if the members will try and limit themselves to approximately 5 minutes for their inquiry, we will give more of a chance for participation to everybody.

We don't have a clock available to us, so I'll just ask everybody to try and cooperate with the chair.

Welcome to the committee, and Ms. Zeidenberg, would you like to start off and enlighten us, in any manner you're comfortable with?

STATEMENT OF ERICA ZEIDENBERG, VICE PRESIDENT, SOFT PRESS, OAKLAND, CALIF.

Ms. ZEIDENBERG. Good morning. My name is Erica Zeidenberg. I'm vice president of Soft Press, a software development company in Oakland, Calif.

I'm here today to highlight a terrible and shocking problem with our nation's health insurance system. Personal experience has proven to me that the insurers are protected by the law, and we are not. My insurance company canceled my health insurance while I was in my 6th month of pregnancy. My husband and I had always paid our bills, and had no unusual medical claims. Shockingly, this cancellation is not only legal, it is fully supported by existing State and National policies.

My husband and I are the only employees of our business. We bought our small business health insurance policy through Beneficial Employees Security Trust (BEST), a national group of thousands of small businesses paying over $60 million in annualized premiums. The underwriter for the trust was New York Life. In mid-January, 1989, we were notified that our health insurance would be canceled on April 1, just 28 days before my baby's due date. New York Life had decided to restructure its small business health insurance business, and canceled five trusts, including BEST. We were only 2 of 120,000 employees and 13,000 businesses who lost insurance.

Because I was still capable of working during this part of my pregnancy, as are most women, I was classified as "under medical treatment" but not "disabled." To our surprise, and the surprise of everyone we know, we learned an insurance company has absolutely no legal obligation whatsoever to continue to pay the bills of someone under medical treatment at the time a policy is canceled. It does not matter that you incurred the medical condition during the term of the policy, or that you will certainly become disabled within days of the cancellation. The insurance company does not

have to pay. Those who are classified disabled are only slightly better off. By law, the coverage continues for 3 to 12 months, depending on the State, a sufficient period for my case, but not for those with long-term illnesses.

We purchased the BEST/New York Life policy because of its maternity benefits. Now we were left without insurance within a month of our baby's birth. Having a baby in California, with no complications, costs about $5,000. A C-section costs about twice that, and any problems can quickly raise that figure to as high as $100,000. We felt we were at considerable financial risk.

I was stunned that our health insurance could be so abruptly canceled, and I was outraged to learn that New York Life could walk away in the midst of medical treatment. At a time when my husband and I should have been excited about the upcoming birth of our first baby, we instead faced the stress of paying major medical expenses.

When we were notified of the termination I could not believe this was legal, and immediately spoke out about my situation. I contacted the California Insurance Commissioner, elected officials and consumer health organizations. The San Francisco Chronicle published an article describing my dilemma, for which a vice president of New York Life was interviewed. My cousin, a prominent attorney, sent numerous letters that were circulated at high levels within New York Life. My congressman had repeated contacts with New York Life's D.C. representative. In fact, at one point New York Life told my congressman, in writing, that they would make an exception to their blanket cancellation and continue coverage for pregnant women. This offer was immediately rescinded by higher-ups.

In the end, New York Life simply would not budge because to give into my case meant possibly taking care of all the sick people among the 120,000 being canceled, and most important, New York Life had the law on its side, and the company knew it.

By giving us a minimum of 31 days' notice of termination, the company had fulfilled all its responsibilities under Federal and California law.

While BEST was looking for a new underwriter, healthy members of the trust could have fairly easily qualified for new insurance with a new carrier. However, because pregnancy is considered a preexisting condition, I could not get new insurance while I was pregnant. For those subscribers like me, with preexisting conditions, New York Life offered a very limited conversion plan. It cost an incredible $19,000 a year, compared to the $3,000 we spent annually under BEST.

I considered inducing labor before the deadline, in spite of the medical risks involved with that choice. I also considered faking my condition and pretending I was disabled, so the coverage would have to continue until the birth, even though I knew I could easily be caught. The only real option was paying for the birth ourselves.

Fortunately for us, BEST obtained a 1-month extension to May 1, while they negotiated details with New York Life, and our son Jonathan was born April 27, with 4 days to spare.

Just at the deadline, BEST found a new carrier, United Olympic. We joined the plan as of May 1. Not all BEST subscribers were in-

vited to join, however, because United Olympic excluded customers who had previously made too many claims.

Because my pregnancy was a temporary condition, and not too expensive, we were able to get coverage; but those BEST customers who had chronic and serious illnesses, like heart disease and cancer, were left with no insurance, and no affordable alternatives.

Today, almost a year later, our small business has experienced severe rate hikes with our BEST coverage. The new plan cost $250 a month to start, the same as we had been paying to New York Life. We added our baby to the plan and were charged an additional $120. We were then paying $370 a month for a family of three.

In December, BEST announced a 28-percent increase starting in January. A quick calculation showed we would be paying close to $500 a month, $6,000 a year to insure our healthy family. This was far more than we could afford.

We now subscribe to a Blue Shield family plan for $170 a month, with a much higher deductible, and no maternity benefits. Unfortunately, at this time we cannot find an affordable business health insurance plan, and will not be able to offer one to new employees as we expand our business. Until it happens, people do not realize they are always just a month away from a health insurance cancellation. We always believed that as long as we diligently paid our premiums on time we had health insurance, and that the insurer was obligated to pay for medical treatment.

It never occurred to us that our biggest concern would be insuring ourselves against our insurer. We feel we were victims of a system that continually finds ways to flush out the sick and expensive customers from the pools of insured. Even a pregnancy can leave a family at the risk of financial catastrophe if there are complications.

New York Life explained in a letter to the California Department of Insurance that our BEST plan was one of five trust programs which proved to be unprofitable, so New York Life had no viable alternative to termination.

Otherwise, they concluded, continuing these programs would result in a serious financial cost to the company. This defense shows how one-sided the system has become. New York Life feels its actions were totally justified simply by citing adverse financial impact to itself. They ignore with impunity the adverse financial impact its actions have on the thousands of businesses who lost their health insurance.

I believe that when tens of thousands of people purchase insurance in good faith and then find themselves denied its protection and without recourse, it is time for the Government to act—to enact the laws that will protect its citizens against victimization by agencies of the health insurance industry.

Thank you.

Chairman STARK. Thank you, Ms. Zeidenberg, very much.

Mr. Nagel.

STATEMENT OF FRED NAGEL, OWNER, FANTASTIC SAM'S, TAMPA, FLA.; ACCOMPANIED BY CINDY NAGEL, ON BEHALF OF THE U.S. CHAMBER OF COMMERCE

Mr. NAGEL. Mr. Chairman, and members of the committee.

Cindy and I consider it an honor and a privilege to be here today to express our concerns and our real-life situation to you this morning concerning health insurance for small business.

As presented in our submitted statement, we are the owners of three franchised hair salons in Tampa, Fla., with 40 employees. We opened our first store in late 1984, and in October of last year we acquired our third store.

I would like to preface my discussion of our insurance problems with how we started our business in order to put the plight of the small business person into perspective. We sold our home in Texas to pursue a small business in Florida. It was a scary feeling for both of us with many sleepless nights, thinking about how we had invested all our savings in the business, not knowing whether it would succeed or not. Looking back, I don't think we would ever jeopardize our livelihood again with this big of a risk knowing the turmoil it put us into, and with the risk of 50 to 85 percent failure rate of small businesses.

At the beginning I worked with another company from August 1984 until April 1986, in order to subsidize our income while Cindy was in charge of the store. Because of my employment with the larger company, we were covered under the company health insurance. After I left to help in our store in 1986, we acquired Av-Med health insurance, an HMO, and we were able to make it available to our employees.

In June of 1989, our insurance was canceled with no explanation. I contacted our insurance representative to ask why and was told that the decision was made at the main office, and that she didn't know the reason for the cancellation.

While we were covered under the Av-Med plan our group had some major claims, and I suspect this was the reason for our cancellation. I had back surgery in February 1987, and Cindy had an exacerbation of her multiple sclerosis in July 1987. Cindy has a very mild case of MS, and this was the first flare-up in about 16 years. Also, one of our employees had gallbladder surgery and underwent extensive testing because of suspected breast cancer, which was later found to be a precancerous growth.

Cindy and I have always had health insurance coverage. When we got married 20 years ago, as our children were born, and as we move it was always a priority. We never had a lapse of coverage until this recent cancellation in 1989. It was a very unsettling experience, and still is since we are not covered for any preexisting conditions. It was nearly 8 months that Cindy had no coverage, and now has a $2,000 deductible in order to keep the premium lower.

We have found through trying to obtain insurance that many insurance companies will not insure beauty salons, and that most HMO's tend to exclude businesses with under 50 employees.

Also, we personally now discovered that even though we have had continual insurance coverage we are now disqualified from obtaining insurance for our preexisting conditions. Another crucial

factor is that the premiums are skyrocketing and becoming unaffordable. Our stores have had 75 percent increase in insurance premiums in the past 14 months, and the threat of cancellation is always there, along with the disqualification of certain high-risk individuals.

We sincerely wish that we could pay for the full health insurance premiums for our employees, but survival of the business must be our first concern. With our combined income last year of $50,000, and the store showing a $1,000 profit, we would literally be put out of business by these health insurance costs, and our employees would be put out of jobs.

It is an unrealistic burden to put this financial responsibility largely on small businesses. We support the chamber's position of returning to the traditional concept of insurance, the spreading of risks across the wide population.

To achieve this goal insurers collectively must change their underwriting practices. This would tend to spread the expense across a larger group, promote competition to the more efficient insurance companies, and offer access to insurance to everyone, including those now excluded because of preexisting conditions.

Cindy and I thank you for this opportunity to present out views and for your effort in finding a solution to this pressing problem that affects us all.

[The statement and attachments of Mr. and Mrs. Nagel follow:]

STATEMENT
on
HEALTH INSURANCE IN THE SMALL GROUP MARKET
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
Fred and Cindy Nagel
April 3, 1990

Mr. Chairman and members of the Subcommittee, my name is Fred Nagel. My wife Cindy and I are owners of three Fantastic Sam's hair salons in Tampa, Florida. We are members of the U.S. Chamber of Commerce and will be testifying on behalf of the Chamber today. We are accompanied by Karen Berg Brigham, manager of health care policy for the Chamber.

We commend the Chairman and the Ranking Member of this Subcommittee for the attention that they have brought to this critical issue. While the problems of spiraling health care costs and growing gaps in health coverage have been well-documented in recent years, the plight of small business in the health insurance marketplace has not. I will focus my remarks upon the specific problems we have faced as a business and as individuals in purchasing health insurance. I will also outline the Chamber's recommendations to address this important issue.

Our Experience in the Health Insurance Market

We purchased our first Fantastic Sam's hair salon in late 1984 and now have three stores. We currently employ 40 individuals. We began to make individual and family health insurance coverage available to our full time (30 hours or more) employees in 1986 through Av-Med, a health maintenance organization (HMO).

In June 1989, we were informed by Av-Med that our policy would be cancelled. No reason was given for the cancellation, and our lawyer informed us that Av-Med had the right to drop us without explanation. I suspect that the cancellation was the result of several major claims by our group in the previous two years. I had back surgery in February 1987. Cindy was diagnosed with multiple sclerosis in 1971. It is a mild case, but she had an exacerbation in July 1987 and required hospitalization and follow-up treatment by a neurologist on an outpatient basis for two months. In addition, one of our employees underwent extensive testing because of suspected breast cancer, which was later found to be a precancerous growth.

After our coverage was cancelled, I was able to acquire coverage through Mutual Benefit Life but only for employees who prequalified after medical screening. My wife and I were excluded from coverage because of our preexisting health conditions. One of our employees, who had been covered under the previous plan, was without coverage for more than eight months as she underwent medical scrutiny because of high blood pressure. She became covered under the new plan only recently.

My family went without any coverage whatsoever for nearly six months. Let me tell you, that is a very frightening situation in which to find oneself. Last month we were able to obtain coverage for Cindy through the Florida State Comprehensive Health Association, the state pool for high-risk individuals. Her preexisting condition, however, will not be covered for a year, and her coverage is subject to a $2,000 deductible. I was able to obtain basic catastrophic coverage (hospital and surgical only) in November of last year for me and our two daughters through State Farm, but with tight restrictions. Any claim having to do with my back, whether or not it is related to my previous injury, will not be covered. One of our daughters has Bell's palsy and a deviated septum and is not covered for either of these conditions. In addition, a deductible of $500 per incident applies to any claim that we make. I feel a little better knowing that we will be covered in case of a major medical emergency, but the thought that perhaps we could end up without coverage again is always at the back of my mind.

In my search for insurers that would be willing to cover our whole group, I was told on several occasions by carriers that they would not write policies for beauty salons. I fear that if our coverage is cancelled again, we will not be able to obtain insurance at all. Cindy has even considered leaving our business to take a job at a large company where she would be able to obtain health insurance without medical screening.

I know from articles and news reports that we are not the only small business in this situation (see attached New York Times article). This is a problem that warrants immediate attention and action by Congress. I will present an overview of the problems small businesses generally face in obtaining affordable health insurance and the Chamber's recommendations to address these problems.

Overview of the Problems in the Small Group Health Insurance Market

According to the Census Bureau, 13 million of the more than 31 million Americans who lack health insurance are full-time, full-year employees and their dependents. Sixty-five percent of the employed uninsured work for firms with fewer than 25 employees, according to the Small Business Administration.

Most small employers want to offer health insurance to their employees. But many currently find health insurance difficult or nearly impossible to obtain -- or completely unaffordable.

Medical cost inflation has taken its toll. Overall, businesses currently face annual health care cost increases averaging 20 percent. Many small businesses have been hit with even larger increases. Since 1980, employer-paid insurance costs have risen nearly three times faster than wages.

Administrative, marketing and brokerage costs add 25 to 40 percent to the cost of health insurance premiums for small businesses. These costs are higher for small businesses because an insurance carrier or agent may have to perform administrative or claims-management functions handled internally by a larger client.

Small businesses face other obstacles as well.

First, small employers usually do not have easy access to managed care plans, which have been successful in restraining costs. Managed care options include HMOs, which provide all health services to members for a flat fee, and preferred provider organizations, in which affiliated medical practitioners provide services at a discount. HMOs often do not write accounts for companies with fewer than 25 employees. In addition, many insurance carriers do not offer benefit plans with aggressive managed care features to their small business customers.

Second, current tax laws discriminate against self-employed (primarily small) business owners by allowing only a 25 percent deduction for their health insurance expenses, while corporations may deduct 100 percent of their health expenses.

Third, small business employers do not have sufficient assets to self-insure their health care risks. These companies must purchase insured plans, which are regulated at the state level. State mandated benefit laws require carriers to include benefits that add an estimated 20 percent to the cost of health plans in some states.

Finally, the increasing trend toward self-insurance by medium to large firms has forced health insurance companies to maximize their profits in the small group market. The forces of very tough competition in the health insurance industry are driving insurance companies to stricter underwriting practices for small business.

Underwriting is how insurers determine who they will cover. Insurers often segregate workers considered to be "high risks" from group rates and price them separately or exclude pre-existing conditions. This segmentation is particularly insidious for small businesses because they are not large enough to average out healthy workers with less healthy workers and also do not have the market clout to insist upon group rates and equal coverage for their employees.

Insurance companies compete on the basis of risk selection. The statistics underscore the reasons. Approximately five percent of the U.S. population account for about 50 percent of national health expenditures; 20 percent account for about 80 percent of the expenditures. Therefore, who is in an insurance company's risk pool is critical to that insurer's profitability.

An insurer with a high-risk clientele must charge more than its competitors and becomes less competitive; moreover, it attracts more of the higher risks who cannot obtain coverage elsewhere. Such a company could pay more in claims than is covered by premiums. This has happened to several carriers in recent years, forcing some out of business. In short, competitively forced underwriting is destroying the insurance market for small businesses.

In an environment where there is no constraint on the risk-selection process, one cannot expect an insurance carrier to sell insurance policies for social policy reasons that will destroy it in the marketplace.

The U.S. Chamber of Commerce's Policy Recommendations

We must return to the traditional concept of insurance -- the spreading of risk across a wide population. To achieve this goal, insurers must change their underwriting practices. The Chamber believes that such changes should include:

- o accepting all employees when providing group coverage to a company;
- o guaranteeing renewal of a group at pooled rates, once the group has been accepted;
- o imposing no new preexisting condition limitations on an individual who has been continuously insured when that person changes employment or coverage; and
- o providing a reinsurance pooling mechanism to provide direct access to small employers who have been rejected to spread risks among participating insurers and HMOs.

Federal legislative or regulatory action likely will be necessary because of the competitive pressures in the insurance industry. Otherwise, insurers that voluntarily make these changes for social policy reasons will end up with substantial losses. We are not, however, recommending community rating. We believe that the underwriting changes and reinsurance pooling mechanism will have a leavening effect upon insurance rates.

We viewed the Pepper Commission's recent recommendations on access to health care as a mixed bag, but were pleased that the small group health insurance market reforms enjoyed broad support among the commission members.

In addition to these changes, there are several other steps that Congress could take to assist small businesses in their search for affordable health insurance. Attached is copy of the Chamber's Statement on Access to Health Care, which outlines specific policy recommendations in this regard. I would like to highlight the importance and relevance of these recommendations:

o Preemption of state benefit mandates. Nearly 700 benefit mandates in the states require insurers to include specific benefits in health plans. One rationale for the benefit mandates is to ensure access to the services of alternative providers. But the practical result has been increased premium costs for businesses that purchase insured health plans -- primarily small businesses. It also has had the effect of driving those businesses with adequate financial resources to self-insure their health risks in order to escape this burden. Consider the statistics: In 1980, fewer than 10 percent of employer-provided health plans were self-insured. Today, 55 to 60 percent of employer plans are self-insured. The Chamber supports preemption of state benefit mandates under the Employee Retirement Income Security Act.

o 100 percent deduction for health insurance expenses of self-employed individuals. Self-employed small business owners may deduct only 25 percent of their health insurance expenses, while incorporated businesses may deduct 100 percent. The fact that health insurance is not fully deductible for the self-employed is certainly one major reason why that

group is the least likely to purchase or offer health insurance. Twenty-nine percent of sole proprietorships with one to nine employees have coverage, whereas 70 percent of similarly sized incorporated businesses (that enjoy 100 percent deduction) have health insurance. The Chamber supports increasing this important deduction to 100 percent and extending it permanently.

o Encouragement of small group pooling arrangements. Group pooling arrangements help small firms to obtain health care coverage on a more cost-effective basis than an individual firm might be able to obtain it. However, confusion exists over the regulatory status of certain pooling arrangements, known as multiple employer welfare arrangements; the Chamber believes that this should be clarified.

Conclusion

Health care is an issue of great importance to the business community. I have outlined positive steps that can be taken right now to help a significant portion of the uninsured population -- the working uninsured. Unless steps are taken to ensure that small -- indeed all -- businesses have access to available and affordable coverage, we might become a nation of medical "have-nots."

Mr. Chairman, the Chamber commends you for your leadership in this area and stands ready to assist you as you continue to work on these issues.

Enclosures

THE NEW YORK TIMES, MONDAY, FEBRUARY 5, 1990

Health Insurers, to Reduce Losses, Blacklist Dozens of Occupations

By MILT FREUDENHEIM

In an effort to avoid losses, many insurance carriers have quietly blacklisted dozens of types of small businesses and professions. A wide variety of occupations, from bartender and gas-station attendant to oil driller and dentist, have been declared ineligible for health insurance.

The exclusions are adding heat to the growing debate over how to protect the 31 million uninsured Americans, more than half of whom are working people and their families. At least three Congressional committees and several state commissions are drafting laws that could help make health insurance accessible to those without it. And the insurance industry, hoping to ward off new Government programs and regulations, is scrambling to come up with its own proposals.

Situation Is 'Just Awful'

In his State of the Union address last week, President Bush said his White House domestic policy advisers would review "recommendations on the quality, accessibility and cost" of health care being developed by Government study groups. A number of Democrats in Congress are working on bills that would require all employers to offer health coverage. Some critics of the insurance industry are also calling for national standards of conduct for insurers.

The situation is "just awful" for small businesses that need health insurance, said James Bissonett, an insurance broker in Eden Prairie, Minn., a suburb of Minneapolis.

The exclusions can have serious consequences for workers in the affected industries. In a number of states, including New York, they may turn to a Blue Cross or Blue Shield plan for coverage, often at a high monthly cost, but in many states such people go without insurance. And many hospitals, doctors and medical clinics will not treat uninsured patients.

While some health insurers have been accused of denying coverage to people in cities and occupations where the insurers contend the AIDS virus is most prevalent, the exclusions extend well beyond these groups. More than 40 industries are listed as "ineligible" in correspondence to insurance brokers from several large insurers. The lists

Continued on Page D5, Column 1

Continued From Page A1

were provided by a New York insurance broker, who asked not to be identified, as examples of the exclusions imposed by many insurance companies.

For instance, a list under the letterhead of the Phoenix Mutual Life Insurance Company, based in Hartford, includes service businesses like laundries, service stations, hotels, motels and restaurants; hazardous or seasonal industries like oil drilling and ski resorts, and health-care providers.

At the Hartford Group, a subsidiary of the ITT Corporation, types of businesses listed as ineligible for medical, disability and life insurance included barber shops, bars, beauty salons, car washes, entertainment groups, fishing enterprises, logging or mining operations, Government-financed nonprofit organizations, drilling and exploration operations for oil and natural gas, scrap dealers, taxi drivers and used-car dealers.

For dental coverage, the same company said chiropractors, dentists, education groups and municipal employees were also ineligible.

Insurance executives cite a number of reasons for the exclusions, which they say are based on their profit-and-loss experiences with such groups. Insurers say that employees of some businesses that sell alcohol, like restaurants and bars, have higher rates of alcoholism, resulting in expensive health problems. They say businesses like lumberyards, munitions plants and sanitation companies can be unprofitable for insurers because of frequent accidents or illnesses.

Other businesses with high turnover and many part-time employees, like motels, convenience stores and hair salons, are excluded because transient employees may be in poor health to start with and insurers find it difficult to verify their health histories, said Henry Raymond, a director of insurance, managed care and provider relations with the Health Insurance Association of America, an insurer trade group in Washington.

"Some industries that have high turnover and low pay may be perceived as occupations that attract an employee whose truthfulness and veracity may be difficult to verify," Mr. Raymond added. He said that in analyzing the health of applicants to decide whether their group should be accepted for insurance and what rates to charge, "it is very difficult to verify what hospital a transient individual went to, or to get a documented health history."

The blacklist goes well beyond those considered likely to get AIDS.

Yet another reason for exclusion, insurance executives say, is a high incidence of claims by people in the health-care professions, like doctors, dentists, nurses, chiropractors and other medical workers. "Because they are highly aware of health-care needs, health providers tend to have a high rate of utilization," said Joan Herman, a senior vice president at Phoenix Mutual.

Administrative Costs

Finally, some groups are excluded because insurers say they require high administrative expenses. Insurers say they usually take several years to earn back the start-up costs of enrolling new members, so they shun clients like local governments that require annual open bidding and may frequently switch insurers. Similarly, they contend that some small nonprofit organizations may lose their financing and drop their coverage before the insurer can recoup its costs.

But many groups say the exclusions are arbitrary and unfair. "I would like to see statistical data to show why the arts community is treated like the ammunition industry," said Ted Berger, executive director of the New York Foundation for the Arts.

Individuals Also Denied Coverage

Arts and dance groups and people like florists and interior designers say their groups are often unfairly excluded on the mistaken assumption that their employees are likely to contract the AIDS virus, even though many states prohibit discrimination against people thought to be at increased risk of AIDS.

Mark Scherzer, a Manhattan insurance lawyer, said small businesses with employees who have consulted mental health therapists were also often refused health insurance.

The exclusions extend beyond certain groups to individuals in small businesses that have not been blacklisted. Many individuals who are ill or have a sick dependent go without health insurance after being rejected

— while their fellow workers are accepted — or after being charged steep rate increases. About 2.5 million Americans are considered medically uninsurable, according to Federal estimates.

"Middle-class folks often don't realize how shallow their coverage is and how vulnerable they are," said Maryann O'Sullivan, executive director of Health Access, a California consumer coalition based in Los Angeles. The most impoverished Americans are insured by the Medicaid program run by states and the Federal Government.

The exclusion problem "has gotten worse over the last few years," said Lisa M. Carroll, health services director of the Small Business Service Bureau, an association based in Worcester, Mass., that arranges group insurance for 35,000 businesses.

Insurers say the exclusions have resulted from rapidly rising medical costs that increase their risks. "We're being told the problems are becoming more acute," said Mr. Raymond of the Health Insurance Association. "We hear it from the state insurance commissioners, customers having trouble getting coverage and on Capitol Hill."

Small Groups Suffer Most

Critics of exclusions, including some insurance executives, say blanket denials of coverage are adding heat to a growing debate over improving access to health care for uninsured Americans. The insurance exclusions are felt most by groups of fewer than 50 employees, whose combined premiums frequently do not meet the costs of a single expensive illness. While insurance brokers say they can sometimes negotiate exceptions to the exclusions, small groups often find the price beyond their reach.

The critics say many insurance carriers now concentrate on the customers considered least likely to have high medical costs, avoiding people who would once have been insured as part of a communitywide group.

"The insurance industry is killing itself softly," said Uwe E. Reinhardt, a health-care expert and professor of political economy at Princeton University. "I understand their business needs, but I would like them to get out of the game of picking the favorable risks and excluding the rest. They are getting a terrible reputation."

Some Insurers Are Alarmed

Ms. Carroll of the Small Business Service Bureau said the restrictions were often unfair. "Even though they may hire part-timers, the owners and operators and permanent office staff are also being excluded," she said. "And most diseases are not industry-specific."

Some insurance executives have also expressed alarm. "We are clearly concerned about accessibility, both as a company and as an industry," said John P. Cole, executive vice president of the Lincoln National Corporation, an insurer based in Fort Wayne, Ind. "What we have to do as an industry is get back in the insurance business, to look at small businesses and take on more risk than we have in the past."

Some insurance carriers have tried to avoid exclusions. Indeed, Blue Cross and Blue Shield associations in some states still accept all applicants, although their rates have also risen steeply and often include added charges for people in cities where health care is expensive, as well as for elderly people, who are more likely to submit medical claims.

The Small Business Service Bureau arranges coverage for pooled groups of its members with nonprofit Blue Cross and Blue Shield plans and health maintenance organizations that have fewer barriers to membership.

Insurance groups are also discussing special pools financed by the insurance industry that would accept high-risk people, spreading the costs of their care among all insurers. Small employers would still pay a premium, but would receive tax credits or government assistance.

Higher Rates for Everyone

At least 18 states have pools that receive little or no government help. Bob Griss, a policy analyst in Washington with the World Institute on Disability, an advocacy group for disabled people, said groups using the pools must still pay high premiums.

Under the current system, unpaid health costs not covered by insurance are transferred through higher rates to everyone who does have coverage. "We all end up paying more," said Dr. Stephen Crane, a health policy analyst at the Boston University School of Public Health.

Insurers voice frustration about efforts to insure small groups. Joseph Fazzino, a spokesman for the Hartford Group, said the company stopped selling group health insurance last year to most businesses with fewer than 50 employees. He said the exclusion list "may still apply to groups of 50 to 100 employees."

"We've found it is very difficult to adequately price small groups," he added. As for government-financed nonprofit agencies or municipalities, "those might be cases where the clients go out for bids on a yearly basis," he said.

Because such policies cannot be easily renewed, the handling expenses are high. "Some of the other cases have many part-time and transient employees," Mr. Fazzino said.

Excluded From Health Insurance

Insurance companies often deny small businesses health insurance because of the nature of the work, the rate of claims or the administrative costs.

Hazardous work

Mines, quarries, oil drillers and riggers, lumberyards, logging operations, farms, ranches, charter and unscheduled airlines, aviation and pilot-training schools, munitions plants, sanitation businesses, asbestos-related industries, pest-control services, scrap dealers.

Low-paying or seasonal work

Hotels, motels, restaurants, car washes, laundries, cleaners, entertainment and arts groups, beauty salons, barber shops, bowling alleys, pest-control services, service stations, convenience stores, farms, ranches, fishing enterprises, golf clubs, ski resorts, camps.

Higher rate of claims

Doctors, dentists, nurses, chiropractors and other medical workers.

Higher administrative costs

Government-financed nonprofit organizations, municipalities.

Source: Insurance brokers

U.S. Chamber of Commerce

Washington, D.C. 20062

STATEMENT ON ACCESS TO HEALTH CARE

I. COMMITMENT TO AN INITIATIVE ON COST, QUALITY AND ACCESS

A policy goal of the U.S. Chamber of Commerce is to increase financial access to health care, constrain health care costs and enhance quality. As health care costs climb nationally, the issue of financial access to care is inextricably linked with the issues of costs and quality. These three issues must be dealt with in tandem in order to forge a consensus of payers, providers and consumers.

II. GOAL: REDUCE THE NUMBER OF UNINSURED PERSONS BY TWO-THIRDS TO THREE-QUARTERS WITHIN A REASONABLE PERIOD OF TIME, AS PART OF A LONG-TERM COMMITMENT TO UNIVERSAL FINANCIAL ACCESS TO CARE

The Chamber supports, as a long-term goal, a system of public and private insurance that would assure universal financial access to appropriate health care. Even while the nation searches for the means to achieve that long-term goal, the Chamber supports immediate action to lessen the number of uninsured through a mix of public and private initiatives. A reasonable target for such short-term steps would be to reduce the number of uninsured by two-thirds to three-quarters within a reasonable period of time. Such an effort will require a partnership of the public and private sectors with neither sector asked to undertake financing burdens more appropriate to the other.

III. PROPOSAL: EXPAND MEDICAID TO ADDRESS THE NEEDS OF THE POOR AND NEAR-POOR

Approximately 32 percent of the uninsured population is poor -- defined as those with incomes below the federal poverty level. Currently, only 40 percent of Americans with incomes below the poverty line receive assistance from the Medicaid program. Differing state priorities and a growing elderly population with chronic care and nursing home needs have diluted the effect of this federal/state program originally designed to increase access to basic health care for the indigent. The U.S. Chamber of Commerce supports a four-part plan to address the health care needs of the poor and near-poor who do not have financial access to primary care coverage:

A. Assure basic Medicaid coverage to all Americans with incomes below the federal poverty level, restoring the original intent of this program and defining clearly the public sector's responsibility.

B. Allow persons with incomes between 100 and 150 percent of the federal poverty level to purchase, for a sliding-scale premium, primary care coverage through Medicaid.

C. Permit persons with incomes above the poverty level who have large medical expenses to "spend down" and become eligible to receive full Medicaid coverage once income is reduced to the federal poverty level.

D. To ease an individual's transition from welfare or Medicaid, provide states the option of paying Medicaid-eligible employees' share of premium and other costs where private employer-based coverage is available.

In recognition of state and federal budget constraints, the Chamber supports various options for phasing-in expanded Medicaid coverage, within the following priorities:

-- Mothers and children, with the youngest children receiving greatest priority;

-- Phase up medical eligibility by percentage of poverty level, beginning with the "poorest poor";

-- Primary care coverage.

IV. PROPOSAL: PROVIDE ACCESS TO STATE POOLS FOR HIGH RISK INDIVIDUALS

A small but socially significant percent of the uninsured population is comprised of nonpoor persons who are unable to purchase private health insurance because they are substandard health risks. The U.S. Chamber of Commerce supports federal legislation which would require establishment of state pools for uninsurable individuals, with losses financed by state general revenues or other broad based funding. Thus far, 16 states have established such risk pools.

V. PROPOSAL: PROMOTE EXPANDED VOLUNTARY COVERAGE THROUGH THE WORKPLACE

Approximately two-thirds of the uninsured population has some nexus to the workplace (i.e. workers, spouses or dependents). The problem among this population is especially prevalent within the small business sector where normal insurance administrative and underwriting mechanisms can make affordable insurance difficult to obtain. The Chamber is committed to finding ways to extend private, voluntary insurance coverage without at the same time producing job loss. Part of this effort must involve creating cost containment and quality improvement inducements that will encourage employers to expand coverage. The Chamber supports the following specific proposals:

A. Self-employed persons and unincorporated firms should be given a 100 percent deduction for health benefits costs. Unincorporated firms are about half as likely as other companies to provide health care coverage to owners and workers.

Currently, these firms may deduct only 25 percent of these costs and even this deduction will lapse at the end of 1989.

B. Multiple Employer Trust (MET) arrangements should be encouraged. These are group arrangements formed to help small firms obtain health care coverage on a more cost-effective basis than such a firm might be able to achieve alone. Use of improved cost containment, quality and appropriateness methods in these programs can make them affordable to larger cross section of employers. However, numerous federal and state regulatory impediments have discouraged the proliferation of these arrangements. If necessary, such impediments should be preempted by federal action.

C. The private health insurance and HMO industries must make special efforts to guarantee the availability of affordable health insurance to small businesses. To that end, insurance underwriting practices that prevent the pooling of good and bad risks within small employer pools must be constrained. Specifically, the insurance and HMO industries should give consideration to: (a) limiting medical underwriting of individuals within a firm (so that the whole group is accepted or not); (b) guaranteeing renewal of a group, at pooled rates, once it has been accepted (no renewal underwriting); (c) imposing no new pre-existing conditions on an individual who has been continuously insured if such individual is changing employment or coverage; and (d) providing a reinsurance pooling mechanism to spread risks among participating insurers and HMOs and to provide direct access to small employers who have otherwise been rejected. Any losses from such a reinsurance pool should be shared fairly based on who benefits from the mechanism.

D. State-level benefit mandates and barriers to managed care programs should be preempted. More than 640 specific state mandates now require insurers to include particular benefits in health plans. (e.g., mental health or chiropractic coverages) which make insurance more costly to employers with insured plans.

There is increasing legislative activity at the state level which has the effect of undercutting cost-containment efforts by limiting managed care arrangements. This involves such measures as limitations on the ability to form preferred provider arrangements or to provide economic incentives to employees to select such arrangements. Such barriers to managed care should be removed by federal or state action.

E. Federal benefit mandates (e.g., Section 89, COBRA) should be repealed or simplified for employers.

VI. PROPOSAL: PROMOTE THE DEVELOPMENT OF NATIONAL MEDICAL PRACTICE STANDARDS TO ASSURE APPROPRIATE AND EFFECTIVE CARE

A significant percentage of services delivered in our health care system are judged by researchers to be either inappropriate or ineffective. Further, research has shown wide variations in the use of procedures across different geographic regions with no apparent medical justification. The development of practice guidelines, review protocols and outcomes-based assessments through a national effort led by physicians and scientists is the key to removing this degree of waste from the system. Use of such standards with due care by physicians should carry with it protection from unwarranted malpractice claims. The Chamber therefore supports:

A. A national medical-scientific effort, supported by expanded Federal funding, to develop and implement national medical practice standards; and

B. Tying the use of such standards by physicians to protection from malpractice claims under state law, provided the physician has used due care in their application.

APPROVED BY THE BOARD OF DIRECTORS JUNE 14, 1989
REVISED NOVEMBER 8, 1989

Chairman STARK. Thank you very much, Mr. Nagel.
Mr. Hansen.

STATEMENT OF KARL E. HANSEN, CLU, PRESIDENT, VITA INSURANCE ASSOCIATION, INC., MOUNTAIN VIEW, CALIF., AND CHAIRMAN, FEDERAL LAW AND LEGISLATION COMMITTEE, TASK FORCE ON HEALTH INSURANCE, NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Mr. HANSEN. Thank you, Mr. Chairman.

I am Karl Hansen, a life and health insurance broker who lives and works in the San Francisco Bay Area. I am here today representing the National Association of Life Underwriters. NALU is a federation of State and local associations which represents 140,000 sales professionals in the life and health insurance industry. I am chairman of NALU's Federal Law and legislation committee's task force on health insurance.

As a health insurance broker, I occupy my time handling the employee benefit needs of over 300 small employer groups, the vast majority of whom employ less than 25 employees. My office is staffed with seven other insurance professionals dedicated to the daily servicing needs of our group insurance clientele.

These services include not only the overall plan selection and pricing needs of the employer group, but also include enrollment and plan explanation to each of the individual employees. Following the implementation of each plan, our firm assists in the typical administration and negotiation needs between the employer and the benefit provider. Perhaps our greatest role is that of educator to both the employer group as the benefit plan designer, and to each employee as an effective and responsible health care consumer.

Mr. Chairman, the NALU federation applauds this committee's efforts to better understand the predicament of all employers, both big and small, in controlling the costs of health care. The problem is multifaceted and one to which no single solution will apply. As you have stated, over 60 percent of workers in the small employer market are currently uninsured through their current employer.

Without question, the primary reason that these persons are without coverage is due to the exorbitant level of cost that medical care has risen to in this country. Those employers who are maintaining group coverage have experienced annual premium renewals reflecting medical plan cost increases from 20 to 40 percent. While most consumers blame the insurance industry for these tremendous gains, they are only a very small player in the inflationary cost spiral.

More accurately, there are a handful of components that act together to subliminally cause the continued escalation of employee benefit plan costs. These factors include medical inflation, a component which continually outpaces the consumer price index. State-mandated benefits, many of which are fostered by special interest groups, solely at the expense of small business, and most large businesses exempt from such mandates.

Cost shifting, which is essentially a hidden tax on all employers, is used to support the inadequate payment levels of Medicare, Medicaid, and other negotiated service contracts.

Increased utilization: Employees are seeking dramatically more, low-level medical treatment, and physicians are utilizing more diagnostic procedures to protect themselves from claims of malpractice.

Again, small employer plans which have been the last to adopt the more effective managed-care programs feel the brunt of this increased utilization in the form of higher plan costs.

Finally, advanced technology and runaway catastrophic claims costs compounded necessary premium increases. All of these common factors are further magnified by the demands and the antiselection of the small group market, wherein it is quite common for employees to seek necessary coverage only at the exact moment of need, thus defining the concept of insurance.

The insurance industry's established underwriting practices prevent the abuse of cost escalation that would ultimately develop by this insurance on demand technique. Unfortunately, some insurance providers have overutilized the underwriting concept at the expense of appropriate broad-base coverage penetration levels.

NALU recognizes that the only appropriate way to avoid costly adverse selection is through a more balanced approach to cost and benefit underwriting.

Another major area of concern to the small employer lies in the pricing practices in the medical insurance industry. While it is true that the overall cost of any comprehensive health care contract will be high, some employers are being charged premiums at twice the rate of similarly situated employer groups. While these practices tend to benefit some groups, at the expense of others, we support the industry's current effort to tighten these cost gaps and create a more balanced and equitable pricing practice.

In addition to this, the NALU federation supports State efforts to more responsibly regulate the imposition of employer mandates and push for statewide consideration of tort reform to curb the escalating number of cases of excessive and unjustified malpractice awards.

Finally, NALU continues to emphasize the need for continuing education in this and other areas for agents of the State and local associations whom we represent.

Again, Mr. Chairman, on behalf of NALU and myself, I would like to thank you for the opportunity to provide you with our testimony this morning.

[The statement of Mr. Hansen follows:]

TESTIMONY OF
THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Thank you, Mr. Chairman, members of the Committee. I am Karl E. Hansen, CLU, an insurance broker who lives and works in the San Francisco Bay Area of California. I am here today representing the National Association of Life Underwriters (NALU). NALU is a federation of state and local associations and represents those associations on matters of importance to them and the 140,000 sales professionals in life and health insurance and other related financial services who are members of those state and local associations. I am chairman of NALU's Federal Law and Legislation Committee's Task Force on Health Insurance.

As a health insurance broker, I occupy my time handling the employee benefit needs of over 300 employer groups ranging in size from 1 employee to over 2,000 employees. The vast majority of these employers, however, employ 25 or fewer full time employees. To satisfy the demands of our diversified clientele, my organization employs eight full time employees and represents dozens of insurance carriers and products.

The role of the insurance professional in todays sophisticated delivery system has become very diversified. Within my own organization, we employ professionals who dedicate themselves full time to the service of our clientele. Included in our daily service functions are such processes as individual enrollment and explanation of plan design, benefit limitations and personal responsibilities, such as deductibles, coinsurance, pre-authorization requirements and penalties, and the effects of inappropriate utilization. We oversee difficult claims situations and interface with the insurance carrier to negotiate the needs of the group and individual client. One of our greatest roles in servicing the small business person is the selection and implementation of the appropriate plan design and cost distribution between employer and employee. Finally, myself and my staff are "on call" 24 hours per day, seven days a week to respond to the personal financial emergencies which our products are in place to protect.

Simply stated, the agents of America serve as the equivalent of the benefits manager to the small employer who needs but cannot afford the "on demand" services and knowledge that we render.

Finally, one of the greatest functions of the agent is the task of educating the employee and employer in understanding the complexities of the medical delivery system and the fact that no matter who cuts the check, we are all the ultimate payors of the services that we as consumers so blindly demand.

My purpose in addressing this distinguished committee today is to share with you a sampling of the daily health insurance interactions between the front line service oriented insurance professional and the beleaguered small business entrepreneur of today.

It is important to understand that the initial purchase and ongoing claims and field administrative burdens of the small group health products available in the market today are primarily handled by the NALU federation of state and local associations on whose behalf I am addressing you here today.

PRIMARY ISSUE -- AFFORDABILITY

Without question, the greatest difficulty in the employer's medical insurance world is that of affordability. As health plan costs have continued to rise, employers have been forced to share a greater portion of the premium cost with covered employees. Concurrently, employers have attempted to increase employee responsibility through the use of increased deductibles and coinsurance provisions.

The net result has been an outpouring of criticism by employees and a frantic market search by employers for "cheaper" yet still comprehensive health insurance products.

Meanwhile, the insurance carriers, in an attempt to maintain a competitively priced portfolio, have increased new application health underwriting requirements and broadened their tier rating structures. These practices, which benefit the healthy risks and compound the costs of the higher risks, have created the greatest outcry from those less healthy insureds who are paying a cost based on their higher morbidity.

This underwriting environment has created many issues, but has done NOTHING to lower the overall combined cost to the general public. Thus, before we analyze the latter practices, it is imperative that we address the issue of COST.

AMERICANS HEALTHCARE PRICE TAG

As agents in the field, my colleagues and I have been constantly dismayed by the public's concept that "health insurance plan costs are controlled by insurance carriers." While it is true that at long last many carriers are becoming more proactive with their managed care programs, which can help to rationalize costs, they do also realize that they must become more cost effective in their important administrative function. The simple fact is that the insurance carrier is **not** the primary cost control component in the medical care delivery system.

There seems to be a misconception that insurance companies are the primary reason for escalating health care costs, the subsequent access problems, and the burdensome crisis faced by small employers not able to afford health care for their employees. While there is a cost to administer any health care program, these administrative costs are not the primary component of the crisis we are facing today. Rather the escalating medical care costs, frequency, and intensity of visits to medical providers, and changes in the reimbursement structures for federal/state programs have thrown the health care world into a dizzy state of continually increased costs. The reasons for escalating insurance premiums to the small employer is a consequence of these changes, not a cause for them.

At this point I feel it is important to establish a few basic principles of fact with respect to the economics of providing health care:

COST = PRICE x FREQUENCY

Price: In health care, the delivery price of the good or service is primarily determined by the vendor (the physician, pharmacist, or hospital) and is compounded by the delivery system and/or payment process (the insurance carrier or claims administrator, for example). Price is always open to negotiated reduction by the user (patient/ consumer) or the payor (insurance carrier/service plan/government).

Frequency: In the vast majority of cases the initial use of a medical good or service is determined by the consumer. When someone is ill or injured, they go to see a doctor or seek medical treatment. Subsequent utilization is also determined by the consumer, albeit influenced by the professional guidance of the medical supplier.

The point to this statement is to focus on the simple fact that the medical CONSUMER is the person who stands in line first when it comes to the decision of controlling costs. While there are always exceptions, as in the case of acute emergencies, it is primarily the consumer who decides if to see the doctor, what course of treatment they will adhere to, and if possible, what lifestyle changes can be implemented to correct the problem in a more natural process.

My mention of the lifestyle component of health care is made by no accident. The growing data continues to support the fact that lifestyle, MORE than clinical medicine, controls the health of America.

Prior to detailing my commentary on the underwriting and pricing practices of my industry, I felt it important to mention the concepts of COST in terms of price and frequency, of the responsibility of the consumer in the cost cycle, and finally of the simple truth that once again the consumer is ultimately in control of his or her lifestyle, which is so important in determining our state of health.

RESPONSIBILITY

The greatest difficulty in today's insurance market is that employees are not willing to assume responsibility for their own well being. They have almost completely lost the original concept of insurance, and the premise that you should only insure those occurrences that you cannot afford to self-insure. "Insurance" seems to have been redefined to mean a means for someone else to pay all of my bills, rather than protection against catastrophic financial loss.

As an example, some of the first comprehensive major medical plans that were created in the early 1950s contained a $100 deductible. That deductible was a tremendous claim insulator, in that hospital room and board rates were only $10-$14 per day, while doctor office visits amounted to no more than $5! The plan was intended for risks which were not easily afforded . . . i.e., those over $100. This $100 figure was also unique in that it was very close to the amount that the average American paid per year for his or her total health care. If we were to bring that plan to the 1990s, appropriately indexed for inflation, we would experience deductible equivalents of over $2,000!

The extremely important statement I am trying to make here is that if such an insulator were in existence today we would see a dramatic lowering of the TOTAL health care cost in America. With consumers being responsible for the first $2,000 in medical care we would see more than just positive lifestyle practices. Equally dramatic, we would witness greater self-education regarding basic health care necessities and self-care techniques. For the first time we would witness a consumerism that would generate a true response to the health care supply and demand cycle, thus generating price competition and a new focus on treatment effectiveness and outcome. We would see people ask questions like, "How much will my MRI cost and what will it potentially tell us about my medical condition?" or "Is the generic drug less expensive and equally as effective?" However, instead of hearing consumer-oriented questions such as these, we see an attitude that is quite different. This underlying attitude is best conveyed by the redundant question: If it is not directly coming out of my pocket, why should I care how much it costs or how effective it might be by comparison to another course of treatment?

Significant research proving the positive effect of increased deductibles and coinsurance levels has been published in numerous reports by the Rand Corporation, and is reflected in the pricing of most insurance products.

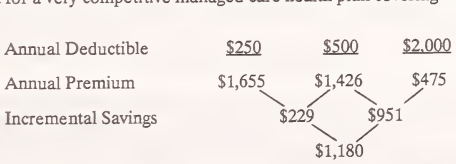
The corresponding premium savings to reintroducing this advanced consumerism (partial self-insurance) would be reflected in increased incomes, with which to pay some of these out-of-pocket expenses when necessary. These additional dollars would be used to self-insure those known costs, which in the State of California, now exceed an average of $2,500 per person per year.

Many uneducated consumers will balk at the concept of such a high level of "insulation" prior to piercing the insurance reimbursement veil, but the fact is that it is essentially the same dollar responsibility that our parents assumed 40 years ago. The simple tragedy is in the market and employment pressures that have maintained this low $100 threshold for almost 40 years and created a perverse cradle-to-grave concept of the best "health care" at somebody else's expense.

The Dual Mentality - Basic vs. Comprehensive

There are, in fact, many persons (typically the entrepreneur) who are anxious to insure their families with a $2,000 or greater deductible! Thus, they are willing to accept the concept of self-insuring the anticipated basic level of care, and realize that such an approach reduces their total cost as they assume personal responsibility in determining need, negotiating price, and controlling frequency of chronic care.

Such personal prudence is reflected in dramatically reduced costs when acquiring appropriate insurance products. For example: the following rates reflect the annual cost for a very competitive managed care health plan covering an individual aged 40.



Observe how the insurance carrier passes on the premium savings needed to "self-fund" the added exposure of the higher deductible. Specifically, by increasing the deductible by $250 to $500 the carrier passes back a guaranteed savings of $229. This savings will be pocketed if health expenses don't exceed $250 during the year. Conversely, should they exceed $500, the employee has only assumed a $21 increase in risk!

Studies based on experience have been done to indicate definitively that when the consumer is directly involved in the acquisition and payment of health care that more appropriate utilization will be experienced, and total health care costs will be reduced.

Despite this logical self insurance rationale, few rank and file employees will attempt to understand the effectiveness of this approach. Rather than catastrophic coverage, they persist in the desire to have full coverage for every trip to the doctor, from sprained fingers to the proverbial runny nose. In fact, this same audience demands significant amounts of preventive care to a degree that far exceeds any evidence of diagnostic outcome effectiveness.

The proliferation of easy and typically free access in the original HMO and PPO models has fostered this concept of no/low cost "comprehensive" care. The concept is admirable, but the resultant runaway utilization has caused most HMO and PPO plans to revamp and increase up front co-pay requirements. Simultaneously, these plans needed to put more stringent focus on the "gatekeeper" role of the primary care physician. While these model plans have always been more successful in rationing the chronic and catastrophic claims situations, they are now starting to experience a low level of utilization overload and a loss of funds due to the inability to shift price to the shrinking population of unmanaged care patients.

The bottom line is that in order to better control costs, we must make each citizen/consumer responsible for a basic "known" level of expense, and the understanding that to "insure" such benefits defeats the concept and principles of insurance.

The purpose of this is to effectively abandon the idea that health care is free. We have the best of healthcare available to us and it is a privilege that the majority of Americans have "someone else" to fund for the majority of it, in the form of employer sponsored group insurance. It IS an unalienable right that we may have the best health possible. It is NOT however an unalienable right that good health be provided by our healthcare system at no expense to to the individual. With this understanding, NALU policy has consistently called for universal access to health care.

The Underwriting/Pricing Tradeoff

One of the classic examples of public misconception about cost is the idea that group insurance is cheaper than individual insurance. It just is not true.

In terms of claims cost, no true group product (that which does not impose medical underwriting) is less expensive than an individually underwritten product. Why? Very simply, the true group product takes all the risks, the good and the bad. The underwritten product weeds out the ultrahigh or chronic risks and reduces benefits on many singular excess exposures. Thus, the claims cost will almost always be lower on an underwritten risk.

What offsets this "underwriting gain" is the administrative cost of the actual underwriting process and the marketing cost created by the uninformed consumer (employer) who is constantly seeking this year's "cheapest plan."

The Anti-Selection Process

The persistence of small group underwriting is equal to the persistence of many small employer groups to seek new or less expensive coverage. Inescapable human nature drives many employers to seek group insurance coverage upon the realization that they or one of their employers has developed a situation which will typically create a potentially significant claim.

As an example, our most frequent inquiry from a "virgin group" (one without insurance) is in connection with an impending pregnancy, surgery or hospitalization. When asked why insurance wasn't purchased earlier, we are quickly informed that it wasn't needed then! This situation, which is almost a daily event, can be equated to calling your casualty agent and requesting fire insurance as the first clouds of smoke rise from the kitchen. Thus the concept of *underwriting*: the small group industry simply cannot afford to take on a new human risk when we know your body is on "fire." Somehow, this concept seems intuitive when speaking of fire insurance, but in contrast, it is almost universally disagreed with when the subject of concern is health insurance.

This same scenario applies to the employer with existing group coverage that has experienced abnormally high renewal costs. Should the health status of the group be deteriorating, it becomes vital that the benefit plan they have chosen is one that has a history of equitable renewal pricing practices. The only appropriate way to avoid costly adverse selection is through a *balanced* approach to cost and benefit underwriting.

Simultaneously, in larger group formats, where liberalized underwriting practices are followed, the use of a short term (typically between 3 and 12 months) pre-existing condition exclusion is utilized to control adverse claims cost.

To eliminate these two practices would drive the cost of small group health insurance *substantially* higher than it is today!

While it is true that many concepts are now being explored at the state level, great caution must be exercised in this area if we are to preserve the affordability of comprehensive coverage in the small group arena.

Industry Pricing Practices

One of the greatest dilemmas to face our industry is the evolving practice of price disparity among similar groups. Many complex factors enter into this pricing practice in which carriers seek to equitably price distinct pools of business, thus maintaining viable total portfolio costs.

A dozen years ago, it was not uncommon for a major carrier to have a "Standard Pool" priced at "manual rates," a "poor risk" pool which was loaded 15%, and a preferred risk pool that shared a discount of 15% off the manual rates. While the *manual rates* reflected the average pricing for all employees within the carriers pool of insured groups, the *loaded* or *surcharged* groups and the *discounted* groups reflected market, demographic, and experience adjustments that allowed more exact pricing.

Unfortunately, many employers and their representative agents, find themselves in a tiered rating situation where they are paying 50%-100% above what might be considered the appropriate "manual rate." This situation is complicated by the proverbial "person on fire" whose insurability is such that they are prevented from moving to a theoretically lower cost carrier.

The reality is that many employers are being assessed a $200 per month employee health rate. While they believe they are being surcharged, they are, in fact, paying a premium amount that is appropriate for the market costs of providing the benefits of the plan and would therefore be charged the same amount by any plan with similar benefit provisions.

The pricing practices of the insurance industry are currently under heavy study by the National Association of Insurance Commissioners (NAIC) and the Heath Insurance Association of America (HIAA). NALU supports the endeavors of all private parties to establish a more balanced and equitable pricing posture in the small group market.

The Components of Health Care Cost Increases

A number of diverse factors have caused the small group employer to be confronted with dramatic and chronic plan cost increases. They include, but are not limited to:

State Mandates: While typical self-insured plans are exempt due to ERISA, most small employers are shouldering an increased burden of "regulated" high cost benefits. Examples of such mandated benefits are: mammography screening and mental illness, alcoholism and drug abuse coverage. While these are without question valid medical expenditures, to require plans to include/offer them only hikes up the cost for all employers.

Simultaneously, many states are thwarting the concerted efforts of the insurance carriers to implement cost effective managed care networks, again at the ultimate expense of small business.

Overall, the system of state regulation has worked well; yet at the same time, we are considering ways in which the barriers imposed by some state mandates can be overcome, without resorting to federal regulation.

Inflationary Trends: Historically, always ahead of the Consumer Price Index (CPI) health care inflation tends to be disproportionately higher, especially in such areas as pharmaceuticals and surgical fees. The non-elasticity of medical supply and demand allows this situation to persevere.

Cost Shift: While some systems such as Medicare and Medicaid are controlling "plan" costs, they are doing very little to contain America's health care price tag. Physicians and hospitals have quickly learned the process of shifting the costs of such uncompensated and under-compensated care to the private sector. HMO and PPO plans with their capitated and negotiated fee structures have further magnified this cost shift. Straight indemnity plans are now to the point where they are almost non-functional due to burdensome excess cost of subsidizing under-compensated care in addition to providing the service of insurance as well.

Unfortunately, it is again the small business owner who was the last person to be offered these negotiated savings. We are now at the point where our medical providers are re-shifting costs back to these original bargain programs, thus the rebounding of costs to many plans which were supposed to offer the "ultimate answer."

Increased Utilization: Because of the cradle-to-grave mentality in the health care system that has come to exist in America, consumption of medical goods and services has dramatically increased. Having been encouraged by the system to believe that the cost of health care services is someone else's responsibility, consumers do not have any incentive to modify their lifestyles, to learn self-care skills or to ask cost questions in the same way they would when buying a new stereo. If stereos were free, I'd take one for the living room, one for the bedroom and one for the car. But since I have to pay for them, one will be sufficient. The point here is that, ironically, this basic principle of consumerism is seldom applied when consuming health care services.

A substantial portion of physician and hospital emergency room visits are for conditions which are either self-limiting (such as muscle sprains and strains), or for which there is no effective treatment (such as the common cold). Additionally, we are witnessing a new growth in alternative medical techniques, many of which have little evidence of therapeutic effectiveness. Such *increased utilization inescapably results in higher plan costs for all employers,* but hits small employers especially hard. As previously discussed, the concept of a higher deductible is the only viable insulation against such increased utilization, putting the responsibility for minor and unnecessary expenses back on the consumer while still offering protection from the threat of being impoverished by a debilitating illness.

Technological Advances: The United States is a culture that firmly believes in the idea of better living through technology, and we have been willing to spend any amount of someone else's money to push back the limits of "mother nature". Advances in computer-assisted diagnostics, surgical techniques, and treatment modalities have brought hope to thousands of people afflicted with illnesses that until recent years have been incurable. Both the research leading up to these technological breakthroughs, and the actual provision of such advanced services carry a heavy price tag. And contrary to the usual laws of supply and demand, the relatively high level of availability of technology has not lowered the cost.

Even though practically every medical center in the country has a magnetic resonance imaging (MRI) machine, the average cost of one diagnostic scan is upwards of $1,000. With high-tech diagnostics being employed even in routine exams, there is a corresponding impact on employers' insurance costs.

Catastrophic Care and Fear of Liability: Related to the technological advances in medical science is the cost of catastrophic care, and the provider's fear of malpractice litigation which again fuels excessive utilization. The American philosophy of continuing heroic measures regardless of the probability for a favorable outcome fuels both of these factors. When faced with the prospect of losing a loved one, the average consumer is willing to go to all extremes to postpone that loss as long as possible. And the average provider feels compelled to explore every possible technique that may extend that loved one's life. If there is the slightest possibility that a $50,000 heart bypass operation will keep a 75 year old chain smoker alive even though the true outcome potential is very slight, most providers will perform that surgery. If an automobile accident victim in a persistent vegetative state might remain alive for a few extra weeks on life support equipment, most providers will continue that life support rather than risk being slapped with a malpractice suit because they did not try every possible alternative.

Reports proliferate in newspapers nationwide about physicians practicing defensive medicine. This level of care is unheard of in other countries, where the concept of death with dignity is respected and upheld by the legal system. The American belief in heroic intervention at any cost cannot help but impact the cost of health care for all Americans.

Conclusion

NALU is vitally concerned with not only the 180,000,000 persons who are covered through insurance and other health service plans, but equally with those persons in our nation who continue to be uninsured.

The problem of COST must be first and foremost in the minds of every political leader. The practice of multiple prices for different entities only exacerbates the cost-shift issue for which we must seek realistic and prudent balance.

NALU promotes appropriate state activity in establishing equitable underwriting and pricing practices among carriers. Additionally, we support the concept of intelligent disclosure of pricing practices so that group consumers can make educated long-term coverage purchase decisions.

NALU continues its efforts in concert with the Life Underwriters Training Council (LUTC) to better educate our affiliated agents in the field of group health pricing, underwriting, and product delivery. To this end, we will continue our dialogue with both employer and employee group insurance consumers wherein we shall attempt to educate them of the realities of effective health cost management.

NALU supports the efforts of the industry to strengthen the Managed Care Concept through appropriate procedure review methodologies, HMO, PPO and EPO programs, and the ultimate rationalization of health care through advanced diagnostic outcome claims management.

Mr. Chairman, there is little doubt that the dilemma of maintaining affordable small group coverage is a complex one. We believe that the one first step that should be fostered nationwide is that of education. The American consumer is yearning for a better understanding of their role in the medical delivery system. Likewise, curbing the escalating health costs of our insurance/medical delivery system *prescribe* that the consumer must, in fact, take on the role of an *educated* medical consumer.

An educational program focused on each individual's personal and social responsibility within the delivery system, the effects of a positive lifestyle, the potential of involved, informed consumerism, and of the ultimate personal financial obligation must be instituted. We believe that the goal of stabilization of health care costing and ultimate access to health care for all persons may be achieved through this mechanism.

Again, Mr. Chairman, on behalf of NALU and myself, I would like to thank you for the opportunity to provide you with our testimony this morning.

Chairman STARK. Thank you very much.

Mr. Gradison.

Mr. GRADISON. No questions.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. I want to thank the panelists for appearing here and putting some faces on the problems that the national statistics have revealed. I think each of our congressional offices have heard stories similar to your account, but it is very important that we have the testimony before our committee, so I want to compliment all of our witnesses here today. It is extremely important to our work, and I hope Jonathan has a happy birthday this month.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you. I appreciate your testimony and have sat through similar experiences with my own constituents, and it is part of the reason we feel such urgency in addressing this problem.

Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Just a brief question, Mr. Hansen.

Like the others, I appreciated the testimony of the others. It is edifying.

Mr. Hansen, is it your position that health insurance should only protect against catastrophic loss?

Mr. HANSEN. That's a very interesting question.

The concept, frankly, is twofold in our Nation. Half—I'm not sure what the numbers are, but the vast majority of consumers, for instance, at the low level really only need basic medical care, similar to what the State of Connecticut is doing, offering a very low-level kind of benefit.

No, that's not our contention at all. The point is that in my written testimony, which I think you might be referring to, we fostered a concept of going to the doctor through many HMO plans, where people go to the doctor for literally no reason—for instance, a common cold, for which there is no treatment.

One of our recommendations is to make the consumer more aware and, as some testimony that has been given this morning, by putting them on the hook, so to speak, and making them a little more responsible, we'll see a more appropriate utilization of the plan and lower cost.

I am trying to address cost in that statement more than just coverage.

Mr. LEVIN. I understand you, but I think that you tend to lose your argument by substantial overstatement.

I mean, you say insurance—and this is on page 3:

"Insurance seems to have been redefined to mean a means for someone else to pay all of my bills, rather than protection against catastrophic financial loss."

There is a lot in between those extremes, isn't there?

Mr. HANSEN. Yes, there is, definitely, and I don't mean to ignore those.

Mr. LEVIN. OK, thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. I have no questions.

Chairman STARK. I want to thank the panel very much. I just want to thank particularly our entrepreneurs who have been ex-

posed to the problems associated with the lack of access. Not lack of access for ability to pay, but virtually lack of access from the supply side of the equation, that there just hasn't been a reasonably priced product available to you.

I am going to assume for the sake of argument that all three of you have exemplary lifestyles; and, if you don't it's none of the committee's business anyway; You aren't sneaking around trying to get sick to put some insurance company out of business, but you have just been had unintentionally by the system.

I hope somehow that we will find a way to take care of half of the equation. There are two sides: some people can't afford to buy anything even if they are reasonably priced products, and those who can afford it or are willing to pay for it oftentimes can't find a product to buy.

Somehow we will see if we can at least work on the supply side of the equation and not have to have people come back and testify to experiences similar to yours.

I want to thank all of the witnesses very much for participating today.

Thank you.

Chairman STARK. Our next panel consists of the Health Insurance Association of America, represented by its president, Carl Schramm; the Blue Cross and Blue Shield Association, represented by Teresa DiMarco, the director of business strategy for the Blue Cross and Blue Shield Plan of Virginia, who is accompanied by Bernard Tresnowski, who is president of the Blue Cross and Blue Shield Association of America; and the Kaiser Foundation Health Plan represented by Kathryn Paul, vice president and regional manager of the Kaiser Foundation Health Plan of Ohio. She is accompanied by Jerry Fleming, who is director of program development for the Kaiser Foundation Health Plan, Inc.

I want to welcome all of you to the committee, and I'll let you enlighten us or expand on your testimony in any manner you are comfortable.

Carl, do you want to lead off?

Mr. CARDIN. Mr. Chairman, may I just——

Chairman STARK. Mr. Cardin.

Mr. CARDIN. One moment. I want to welcome Carl Schramm to our committee. He is a constituent of mine; you welcomed your constituent a little bit earlier.

My constituents don't quite have the same distance to travel in order to attend a hearing in Washington, but I very much appreciate Carl's presence here before our committee and the good work that he has done in our community.

Mr. SCHRAMM. Thank you, Mr. Cardin.

STATEMENT OF CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, BALTIMORE, MD.

Mr. SCHRAMM. Thank you very much, Mr. Stark. It is a pleasure to be here.

I am the president of the Health Insurance Association of America. Our 320 member companies write insurance on about 95 million Americans.

As you know, through the course of my appearances here during the last 2 years, the commercial health insurance industry has been committed to the process of examining what it is that America needs to make our pluralistic system of financing better.

We proposed over 2 years ago a skeletal program for reform intent on covering those 31 to 37 million people without health care coverage. This proposal included expansion of Medicaid, the extension of Federal preemption of State-mandated benefits to insured plans so that we could develop affordable prototypes for everybody participating in the market, equal tax treatment for small businesses, and the invention of a reinsurance plan to guarantee access for small groups.

I have come today specifically to address the question of small group reform. As a prelude to that, I emphasize that which has been said before, ultimately the disintegration of the small group marketplace has its roots only one source, and that is the unrelenting price inflation of the provider community.

With that said, we can point out the indicia of this erosion. It is the employer churning, which we have heard about this morning, the development in the last 3 or 4 years of the practices known as tier and durational underwriting, and the continued creation by employers, as they have been referred to here, "entrepreneurs," of more and more pressure in the market on insurers to develop more and more affordable products for their specific needs.

Overall, the industry believes that these practices have resulted in several regrettable outcomes, not the least of which is extraordinary instability in the insurance market, the continued sifting of risks, higher administrative costs all around, and more and more persons being found each year to somehow be uninsurable and unable to participate in the market.

That is why, over the course of the last few years the HIAA Board has committed this industry to a proactive program of reform, and on February 21 of this year, the HIAA board adopted a comprehensive set of recommendations for changes in the small group market.

Let me emphasize that, for these proposals to work, we must make sure that they apply to all players in the small group market. All competitors in the small employer market, insured and noninsured would have to be bound by the same rules in order to prevent any company or market segment from being disadvantaged.

To make sure we all understand ourselves, the industry has proposed a set of rules which I will now detail. These rules must in fact be enshrined in regulation and statute to make sure they apply to everyone with the force of law.

Under the HIAA plan, the first precept would be that no employer with fewer than 25 employees who seeks health insurance would be denied coverage even if one or more employees might be in bad health or otherwise uninsurable in today's world. We would essentially require insurers to make sure that insurance is available in the marketplace.

Once insured, neither a group nor an individual in the group would be denied coverage in the future because of deteriorating health status, either of the group or of the individual.

At the outset, no group would pay more for basic coverage than 50 percent of the average cost of similar groups in the marketplace.

Fourth, a limit would be placed on the rate of year-to-year premium increases relative to other groups insured by the same carrier, as well as how much a carrier's overall rates could vary among similar groups.

This last point would be enacted, as we see it, to ensure that a carrier would make a long-term commitment to a group.

The fifth point, coverage could not be denied nor new preexisting condition restrictions applied to any insured individual changing jobs or changing carriers. Thus, once a person was in the insurance net, that person would be in the insurance net into the foreseeable future.

Sixth, a privately funded and administrated reinsurance mechanism would be established so insurers could reinsure high-risk individuals emerging out of the initiating carrier's experience.

Seventh, medical underwriting would be allowed only for the purposes of, at the time that the case was sold, determining whether or not the insurer would seek to cede the risk of an individual to the reinsurance mechanism.

The individual and the group would have no knowledge of the reinsurance of any single individual.

These reforms, we believe, are necessary. Since the 21st of February, the industry, through the HIAA and the Insurance Association of Connecticut have gone forward in Connecticut and sought statutory force for these reforms in a bill that is pending and likely to pass in the Connecticut Legislature.

We believe these steps go a long way to insuring that our part of the bargain, in terms of market reform, is accomplished, mainly making insurance available to the small group market, and, to some extent, making it affordable, in the sense that we would erect rate limitations both at the initial offering of the coverage and also at the time of renewal.

Our goal is a stable market where employers and individuals understand they have a stable relationship with their carrier. We have made it somewhat affordable; we cannot make insurance totally affordable for this market given what I cited at the outset, the extraordinary inflation of the underlying provider cost.

Mr. Chairman, these recommendations were adopted by our Board with the clear knowledge that they will exact some pain in this industry in the short term, and that they do represent our industry's firm commitment to provide a responsive insurance marketplace meeting the needs of the small employer community.

Thank you.

[The statement of Mr. Schramm follows:]

STATEMENT OF CARL J. SCHRAMM, HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Carl J. Schramm, President, Health Insurance Association of America. HIAA is a trade association of 320 private health insurance companies which provide health insurance for 95 million Americans.

Mr. Chairman, the escalating spiral of health care costs continues to plague our society. The members of this committee have seen in exquisite detail its effects on the Medicare program. The poor have felt first-hand its ravages on Medicaid. The private health insurance market has been no less immune to its deleterious effects.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of the small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Mr. Chairman, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policymakers. On February 21st the HIAA Board adopted a comprehensive set of recommendations that we believe can be achieved in the context of a viable private marketplace. The essence of our proposals is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that, to work, these changes will have to apply to all players in the small employer market. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage.

The small employer market precepts we recommend are:

1. If a carrier chooses to cover an employer group, it would be required to accept the whole group. Individuals could not be excluded from coverage within the group for health reasons.

2. At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be cancelled because their health had deteriorated.

3. Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Therefore, when individuals are covered in the system, they would not have to face new preexisting condition restrictions, once those requirements have been fulfilled, in the event that they change jobs or their employer changes carriers.

4. There should be meaningful limits on how much an insurance carrier's rates could vary for employer groups of similar composition (similar demography, geography, benefit design and industry). This also would involve limits on how much a carrier could raise its rates for a specific group above and beyond general increases in trend factors.

5. Insurance carriers would retain the right to medically underwrite for purposes of assessing risk and setting rates but not to exclude individuals from coverage in a group plan.

6. Finally, a major objective of these reforms should be to ensure a viable private marketplace over the long term.

These precepts were adopted by the Board with the understanding that they will exact some pain for the industry in the short term, but are critical for coverage of the small employer over the longer term. They represent our industry's commitment to meeting the needs of the small employer community by providing a responsive insurance marketplace.

To give effect to these proposals, government must authorize a private not-for-profit reinsurance organization. Otherwise, these reforms are not achievable. This organization would allow carriers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. Consistent with the small employer market changes, the proposal does not envision breaking up groups for purposes of reinsurance. Rather, insurers would treat all individuals in a group the same way; all members would have the same benefits. The reinsurer would stand behind the carrier and simply reimburse for claims associated with reinsured individuals. This will allow us to assure that high risks are spread, broadly through the private market rather than concentrated in one small employer group.

The reinsurance mechanism naturally would sustain financial losses or shortfalls, since carriers would reinsure only persons whose claims are expected to exceed the price of reinsurance. The intent of the proposal is that losses be financed privately. Losses first would be spread across carriers in the small employer market up to four percent of premium. If losses were not absorbed fully by the small employer market, a second tier of losses would be spread across health benefit plans of small and large employers, up to one percent of premium and premium equivalent. In the unlikely event that the second tier were inadequate to absorb reinsurer losses, it might be necessary to consider a safety valve -- broad-based government funding.

These proposals will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. They will restore the concept of pooling risk across large groups, greatly limiting how much of the cost of poor health must be borne by the individual employer. Further they will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and thereby reduce the incentive to change carriers frequently.

With our recommended market changes in place, the small employer will stand to benefit greatly from our rapidly evolving cost management capacity. These reforms will encourage competition based on efficiency rather than just selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that skyrocket once an employee gets sick. Insurers that reduce inefficient administrative costs and that offer cost-effective financing systems and delivery networks will gain a larger share of what is an extremely price-sensitive market.

There are further steps that Congress should take now to assist small employers with the high cost of health care.

First, the existing preemption of state mandatory benefit laws that currently applies to self-insured employee health plans should be extended to insured plans. There are over 800 different state mandated benefit laws nationwide, ranging from acupuncture and Chinese medicine to pastoral counseling and mental health benefits, from wigs to in vitro fertilization. The cumulative effect is a hodgepodge of state laws that increase the cost of health insurance to small employers who are most in need of relief from the high cost of health care. Small employers should not be forced to choose between a "Cadillac" plan and none at all.

A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of the added cost of state mandates.

Second, owner-employees of small businesses should not be forced to incorporate to get a 100 percent deduction for their health insurance plan. The 25 percent deduction which expires this year should be extended and increased, giving self-employed individuals a 100 percent deduction for their health insurance protection as long as they provide equal coverage to any employees.

Third, as part of a Medicaid reform package, we recommend that all Americans with family income below the poverty line be covered by Medicaid, whether or not employed. States should also be allowed to reduce federal and state costs by reimbursing for the employee share of available employer plans for poor Medicaid-eligible workers (in addition to already authorized transition payments for former welfare recipients).

Mr. Chairman, I want to emphasize that it is definitely not business as usual in the insurance industry. Besides the small group market insurance reforms which I have already discussed, the nation's insurers are moving on their own against what we know to be the root cause of so many of our problems, the ever spiralling cost of health care. There is a sea change under way in how insurers do business. Our companies are making, and have already made, major investments in managed care. They are no longer solely in the role of risk-spreading and claims processing. They are actively taking on the role of health care managers, devoting major efforts to the goal of getting better value for the health care dollar. The information technology that becomes more sophisticated each day increases our ability to make sound health care judgments on value, on quality, on underutilization as well as overutilization, on efficacy and outcomes. This role is a very different one from that of the traditional health insurer our companies previously fulfilled.

We recognize that there is no magic bullet to solve the egregious problem of unacceptable health care cost escalation. However, we in the private sector recognize that there is a substantial problem and have developed a very effective private sector tool which is just beginning to be used.

Will it work? Our nation's business leaders think so. According to a survey of Fortune 1000 senior executives conducted by the Roper Organization, Inc., more than two-thirds (68 percent) believe that managing health costs through networks such as health maintenance organizations and preferred provider organizations is, or could be, effective; 89 percent of the executives polled have made changes in their corporate health plans targeted at containing costs; and an overwhelming 94 percent oppose national health insurance as a solution for the escalating health financing crisis. The vast majority clearly think the private sector should take responsibility for solving their health care financing crisis.

Working together with government, we think we can make a substantially better tomorrow for us all.

Thank you.

Chairman STARK. Thank you.

Ms. DiMarco.

Mr. TRESNOWSKI. Mr. Chairman, I'll introduce Ms. DiMarco, if I may.

Chairman STARK. Mr. Tresnowski.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, ACCOMPANIED BY TERESA DIMARCO, DIRECTOR OF BUSINESS STRATEGY, BLUE CROSS AND BLUE SHIELD OF VIRGINIA

Mr. TRESNOWSKI. I am Barney Tresnowski, president of the Blue Cross and Blue Shield Association.

Since the beginning of the debate on the uninsured, there has been a special focus on the problems of small employers. More recently, the focus has sharpened on problems in the small group insurance market, and specific concerns here include the cost of coverage and the availability of reasonably priced insurance products for groups that have very high risk, high cost employees.

In my prepared testimony, which I would appreciate being submitted for the record, I have commented on both of these problems—problems that Congressman Gradison raised earlier this morning: affordability and availability. In passing, I would say that affordability, as has been testified to several times this morning, is fundamentally an issue with the various factors impacting health care costs, a subject that this committee knows as well as anybody working in this industry does.

But beyond those general health cost increases, the small group market faces additional costs from State legislative and regulatory actions mandating certain benefits. These mandates can add as much as 20 percent to the cost of benefit packages. There are other factors that impact the affordability of coverage: the adverse selection problem that Mr. Trapnell talked about this morning. You get into an adverse selection spiral, driving better risks out of the market.

There is also the fixed cost of insurers spread over a fewer number of persons. The small group insurance market is further affected by 40 years of evolutionary changes in insurance practices. Mr. Jones this morning talked about slippery slope, and enrollment practices have moved from the earlier days of the Blue Cross and Blue Shield open enrollment for all regardless of health status to risk selection practices of many insurers today.

Pricing and rating practices have moved from community rating to demographic and experience-rating to avoid poor risks or avoid being priced out of the market.

Blue Cross and Blue Shield Association believes deeply that the insurance industry must find a way to move the small group insurance market from one where competition is based on risk selection to one where competition is based on administrative efficiency, service, and the ability of the carrier to control health care costs.

However, in making these changes, we would urge the committee to think about the positive business practices of many Blue Cross and Blue Shield plans that have continued open enrollment and

liberal underwriting and rating practices, as pointed out this morning, supported, in part, by various forms of subsidies.

The point I'm making is that the book of business of all Blue Cross and Blue Shield plans has on the average consisted of a greater proportion of substandard risks than other carriers. This simply means that, as we move to reform insurance practices, we not disadvantage those insurers that have tried over the years to serve community needs.

Finally, let me return to the issue of State-mandated benefits, if I may. It is imperative that mandates be preempted. States like Virginia and the State of Washington have enacted laws exempting certain insurance products from these mandates.

Blue Cross and Blue Shield plans in both States have responded by developing low cost products for small employers.

With me today is Teresa DiMarco from Blue Cross and Blue Shield of Virginia, who will discuss their new products for the uninsured small employers.

[The statement of Mr. Tresnowski follows:]

STATEMENT OF BERNARD T. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and Members of the Committee, I am Barney Tresnowski, President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 80 million Americans.

Since the beginning of the national debate on the uninsured, there has been a special focus on the problems of small employers.

The major problem has been the large number of people working for small employers who do not have health insurance coverage. Statistics show that employees of uninsured small groups and their dependents could represent as much as 40 percent of the total uninsured population.

More recently, the focus of debate has sharpened on problems in the small group insurance market. Specific concerns include the cost of coverage and the availability of reasonably priced insurance products for groups that have very high-risk, high-cost employees.

In my testimony, I will comment on both of these concerns. First, I will address the larger issue of affordability. Second, I will discuss the nature of the small group health insurance market, why it has changed over time, and what these changes mean to carriers that have been more responsible in offering insurance coverage in this market.

Affordability

In addressing the larger issue of why many small employers find health insurance unaffordable, it is important to understand that there are many components of health care cost increases, including practice patterns of providers, consumer demand for health care services, new technology, demographic changes, costs associated with medical malpractice and excess capital.

Blue Cross and Blue Shield Plans have a long history of working to control costs directly. Plans have worked to control hospital costs through contract arrangements that limit subscribers' liability while assuring that we pay only a reasonable amount for covered services. We also have contract arrangements with physicians that limit payments to amounts that are reasonable and protect subscribers from "balance billing." In addition, Plans have pursued, over the years, aggressive programs to control unnecessary utilization and avoid the provision of services that are not medically necessary.

In fact, Congress used our hospital provider agreements as a model when Medicare was first enacted, and more recently, they used our participating physician program as a model for the Medicare part B program.

Our focus on cost control has sharpened in recent years as overall health care costs have escalated. Our current cost control efforts include selective contracting, case management, managed care and more intense utilization and medical necessity reviews.

We believe that through these and other measures there is much the insurance industry can do to manage and restrain increases in subscribers' costs.

However, it is important to understand that even with the most aggressive efforts to use only the most efficient providers and to manage subscribers' use of the health care system, the cost of health care will remain out of reach for many employers, and in particular small, marginally profitable employers. Our own surveys make clear that the overwhelming reason small employers do not provide health benefits is cost.

This cost problem is one faced by all purchasers of health care, not just employers. Federal and state governments have been struggling for years with rising costs in the Medicare and Medicaid programs. For example, despite many efforts to control costs in the Medicare program, spending for physician services increased at an average annual rate of 14.4 percent between FY 1980 and FY 1988. Total Medicare expenditures increased by more than 250 percent during this same time period.

In addition to these overall cost problems, small employers face additional costs from legislative and regulatory actions. In particular, the cost of state mandated benefits can add as much as 20 percent to the cost of coverage for small groups in some states.

Many large employers have avoided the cost of these mandates by self-insuring. However, small employers do not have this option because they cannot bear the risk of an occasional large claim -- which could bankrupt the employer and leave a very sick employee without coverage.

Pre-empting these state mandate laws, at least for small employers, through an amendment to the federal Employee Retirement Income Security Act (ERISA), would allow insurers to develop lower-cost benefit packages that would be more affordable to small employers.

Two states, Virginia and Washington, have enacted laws that make small group coverage affordable by exempting certain insurance products from these costly state benefit mandates. Blue Cross and Blue Shield Plans in both states have responded by developing low-cost products for small employers. With me today is Teresa DiMarco from Blue Cross and Blue Shield of Virginia, who will discuss their new product for uninsured small employers.

While overall costs of health care and state mandates are the major factors which contribute to higher insurance costs for small employers, others factors include:

- Greater exposure to adverse selection, that is, the risk that a group will be a worse than average risk. Small employers, much more than large employers, will purchase coverage because of an immediate or predicted need for health care services by the employer, a family member or an employee. Conversely, dropping coverage may be triggered by that need's ceasing. This means that the small group market, much more than the large group market, tends to be made up of people who actively are using health care services. The consequent higher benefit payments result in higher premiums for small employers.

- A smaller base of employees and premiums over which to spread expenses. Health insurance contracts entail certain fixed expenses, resulting in higher expenses as a percent of premium for small groups.

- Higher claims due to the unavailability of workers' compensation coverage. Unlike large employers, not all small employers provide workers' compensation benefits to their employees for on the job accidents. As a result, health insurance premiums for these small employers reflect the added cost of providing protection for such accidents. These costs can be significant.

- High turnover of small group contracts, in part because of the extreme price sensitivity of small employers. Such turnover contributes both to higher claims costs -- because groups that leave tend to be lower-risk -- and higher administrative costs -- because groups frequently leave before an insurer can recoup fully the costs of enrolling the groups.

Notwithstanding these cost issues, however, we recognize that certain insurer practices have an affect on both the cost and availability of coverage for small employers. With these

concerns in mind, Blue Cross and Blue Shield Plans across the country have developed innovative products designed to meet the needs of small employers and other segments of the uninsured population, such as children and young adults and low-income individuals and families.

The Changing Small Group Market

Enrollment Practices: Availability of insurance for high-risk groups was not an issue when the concept of health insurance was first developed. When Blue Cross and Blue Shield Plans began providing insurance coverage in the 1930s, every applicant was accepted for coverage, regardless of health status.

However, as competition was introduced into the health insurance market, it became increasingly difficult for carriers to accept all applicants and maintain competitive prices.

In a competitive market, insurers that accept all risks, or have even marginally more liberal enrollment practices, find themselves with a worse mix of risks in their insurance pools than insurers that have been more selective.

Consequently, the average rates of these carriers are higher than the average rates of more selective carriers. These higher rates reflect the fact that only a few high-cost enrollees can generate substantial claims costs. On average, only 4% of insured individuals generate 50% of claims expenses, while 20% of enrollees generate 80% of claims.

As a result, carriers that end up with subscribers from the "4% category" -- because of more liberal enrollment practices -- will experience higher claims costs and therefore will have higher rates than their competitors. In other words, insurers that enroll the worst risks have the highest rates, while insurers that enroll the best risks can offer the lowest rates.

In response to these price differences, insurers with more liberal enrollment practices lose their low-risk enrollees -- who can find better-priced coverage elsewhere -- and keep their higher-risk enrollees, who have nowhere else to go.

These carriers thus are left with risk pools that gradually deteriorate over time -- because as rates are increased to reflect the costs of their higher-risk subscribers, they lose the next level of lower-risk enrollees to their competitors.

This phenomenon is known as the "adverse selection spiral" and it explains why few insurers can continue to accept high-risk groups and still remain competitive. It also explains why more groups are found to be "uninsurable" or insurable only at high cost.

These selection problems are particularly acute in the small group market. Small employers, who typically have marginal profitability, are extremely price sensitive and are more willing than large employers to switch insurers to get a lower price. This price sensitivity has increased in the last 5-6 years as health care costs have escalated.

The increase in small employers' price sensitivity has accelerated insurers' risk selection practices, because the way to have the most competitive price is to not accept the highest-risk groups.

I would note that the practice of imposing waiting periods for pre-existing conditions on new subscribers is a long-standing and accepted practice in public as well as private health insurance programs. This practice maintains the principle of insurance as providing protection against an unexpected risk. Without such waiting periods, individuals could buy insurance only when they needed it and then drop the coverage after that need was met. Without waiting periods, insurance costs for everyone would increase dramatically.

Pricing (rating) Practices: Another area of concern is insurers' pricing or rating practices. In particular, there is concern about the wide variation in rates that can be charged to small groups and the use of a group's own experience in determining these rates.

In addition to accepting all applicants, the other early practice of Blue Cross and Blue Shield Plans was to offer coverage at the same price to every subscriber in a given area -- a practice known as community-rating. In this way, the cost of coverage for groups with the poorest health risks was kept at the most affordable level possible, because lower-risk enrollees heavily subsidized the costs of higher-risk enrollees.

However, as competition increased in the health insurance market, for the first time lower-risk groups could find coverage that more closely reflected their own risk. The movement of these groups to lower-priced competitors was the first step toward segmentation of the health insurance market.

This phenomenon occurred first in the large group insurance market, but in the last few years it has moved rapidly into the small group market.

In order to avoid triggering the loss of their very best risks to lower-priced coverage -- and the subsidy these lower risks provide for other subscribers -- Blue Cross and Blue Shield Plans and other insurers with more liberal enrollment practices had to find a way to hold onto their low-risk subscribers.

Importantly, one way to keep these low-risk subscribers is to give them a rate that balances the need to more closely reflect their risk while still helping to subsidize higher-risk subscribers.

For example, on average, 55-year old males costs 4 times as much to cover as males under age 30. Insurers might balance the need to keep rates attractive for younger subscribers with the need to keep coverage affordable for older subscribers by setting rates for the younger subscribers at half the price available to the older subscribers.

Insurers with worse risk enrollment mixes need to make these kinds of adjustments to be able to offer competitive rates in the marketplace and affordable rates to higher-risk enrollees.

BCBSA Response

The Blue Cross and Blue Shield Association believes that the insurance industry must find a way to move the small groups insurance market from one where competition is based on risk selection to one where competition is based on administrative efficiency, service, and ability to control costs.

In considering ways to bring about these changes, it is important to keep in mind that the current practices did not evolve overnight but rather developed over time in response to very real market pressures. Congress, the states and the insurance industry will have to work together in balancing the need for change to benefit some small employers against the potential disruptive effect of those changes on other small employers.

As with changes in any industry, a transition period will be critical in maintaining stability. Without such a period, any changes could have the most negative effect on those insurers that have contributed the most to addressing the problem.

The Blue Cross and Blue Shield Association also believes that it is absolutely imperative to address the affordability problem by eliminating state mandates, at least for small employers. These mandates add considerably to the cost of coverage and preclude insurers from fashioning the most cost effective benefit packages.

Finally, we believe it is imperative that any proposal designed to improve access to health care must address directly the underlying problem of escalating costs. Unless health care costs are brought under control, small employers will continue to face the same problems that to date have precluded them from offering their employees benefits -- that is, the cost of coverage.

Given the objective of assuring private coverage for all small employers, the Blue Cross and Blue Shield Association is developing options that would assure availability of private coverage to all small employers at a fair price. Some insurers already are able to accept all applicants for coverage regardless of their health status. Many Blue Cross and Blue Shield Plans can do this primarily because of their large size and negotiated provider payment arrangements. However, other insurers will need some assurance that they will be protected against a disproportionate enrollment of higher-risk subscribers. We are developing mechanisms to assure a fair distribution of these costs.

We also recognize that the use of rates that more closely reflect the risk of a small group has resulted in rates for some groups that may be significantly higher than the rates charged to other groups.

The Blue Cross and Blue Shield Association is developing ways to address this variation. We believe it is possible to begin to limit the range of rates charged to small groups, which would help lower the cost of coverage for higher-risk groups.

This is a very complex issue and "solutions" to the affordability problem that would require an insurer to offer coverage to all enrollees at the same rate are very problematic.

Insurers that traditionally have had, or continue to have, more liberal enrollment practices can easily be placed at a major competitive disadvantage. As discussed earlier, their enrollment of higher-risk, higher-cost groups would result in an average or single rate that would not be competitive in the marketplace. And perversely, it would reward carriers that have been very selective in the risks they accept.

Ironically, this approach also could have the effect of increasing the number of uninsured groups. Uninsured groups tend to be comprised of younger and healthier employees who choose not to spend their wages on health insurance when they do not believe they will need it. If rates are "averaged out", the cost for higher-risk groups may decrease, but the rates for younger, healthier groups will increase. As a result, more price sensitive groups may well drop their coverage.

In conclusion, the Blue Cross and Blue Shield Association shares the Committee's concerns about the cost and availability of insurance coverage for small employers, and we look forward to working with you to find a way to assure availability of coverage at a fair price.

Thank you for the opportunity to present our views today.

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Ms. DiMarco. Mr. Chairman, and members of the committee. I am Teresa DiMarco, director of business strategy for Blue Cross and Blue Shield of Virginia. I am here today to talk to you about a new product we have developed to make insurance coverage for small employers in Virginia both more affordable and more available.

Prior to developing this new product, Virginia analyzed the available information on the uninsured population in Virginia, including demographic information, health care perceptions and medical needs.

As studies of other uninsured populations have shown, almost half of uninsured Virginians are working, and many of these workers are employed by small businesses that do not provide health insurance. These studies also show that these businesses cite cost as the primary reason that they do not purchase health insurance.

This affordability barrier created a challenge for Blue Cross and Blue Shield of Virginia. In trying to address the needs of small employers for more affordable benefit packages, we had to balance the goals of providing low-cost coverage and providing coverage of important, necessary health care services.

To lower the cost of coverage, we designed a benefit package that includes limited up-front deductibles, small per visit copayments, and an annual benefit cap. We chose this approach over the use of substantial up-front deductibles because we believe that most uninsured Virginians cannot afford big deductibles and that they might be denied access to care if they could not pay for the initially uncovered services.

We recognized that another important element in lowering the cost of coverage for small employers was an exemption from State laws which required insurers to include coverage of a wide range of benefits and providers in all their benefit packages.

These State mandates add between 12 to 16 percent to the cost of benefit packages in Virginia, added costs that clearly place insurance coverage out of the reach for some small employers.

For these reasons, we have worked with our State legislature this year to enact legislation that waives these mandate requirements for products offered to small employers that meet certain requirements.

Because of the product design and the exemption from State benefit mandates, Blue Cross and Blue Shield of Virginia is able to offer a low-cost benefit package to small employers in our State. Our product will cost roughly $85 per employee as compared to standard comprehensive coverage, which averages about $140 per month. Family coverage will cost about $225 per month, substantially less than the cost of standard family coverage, which averages between $350 to $400 a month.

Our product places a strong emphasis on providing coverage of routine and preventive services. We will provide coverage of well-baby care up to age 6, 2 annual physician visits and 1 annual dental visit for children, each paid at 100 percent after a $10 copay. These are all services that are important to this population, and we want to ensure that no subscriber is denied access to these services because of cost considerations.

In addition to these preventive services, we will also provide full coverage of maternity benefits, including pre- and post-natal care and an educational and screening program to decrease the likelihood of premature births. Other covered services include inpatient hospital benefits, outpatient surgery, home health care and accident care.

Blue Cross and Blue Shield of Virginia will make this product available to uninsured small employers, those with less than 50 employees, who have not offered coverage for the previous 12-month period. Any group which meets these guidelines will be accepted for coverage. Unlike other carriers in the market that exclude companies in certain industries or exclude high risk members of a group, we will not deny coverage to any employee or small group because of any health-related conditions.

Also unlike current practice in this market, we will not base the rates for this program on the individual health status or age of each member in the group. Instead, the premiums for each employee will be the same, thereby making coverage more affordable for the high-risk employee who may have been priced out of the market previously.

Mr. Chairman, I thank you for this opportunity to address you today, and I would be glad to take any questions.

Chairman STARK. Thank you very much.

Ms. Paul.

STATEMENT OF KATHRYN A. PAUL, VICE PRESIDENT AND REGIONAL MANAGER, KAISER FOUNDATION HEALTH PLAN OF OHIO, ACCOMPANIED BY JERRY FLEMING, DIRECTOR, PROGRAM DEVELOPMENT, KAISER FOUNDATION HEALTH PLAN, INC., CALIFORNIA, BOTH ON BEHALF OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

Ms. PAUL. Mr. Chairman, and members of the subcommittee.

I am Kate Paul, vice president and regional manager for Kaiser Permanente in Ohio. I am accompanied today by Jerry Fleming, director of program development for Kaiser Permanente in our northern California region.

We are both testifying today on behalf of the Kaiser Permanente Medical Care Program.

The program is an economically, self-sustaining, organized health care delivery system that provides benefits on a prepaid, direct service basis to more than 6.4 million members in 16 States and the District of Columbia.

The program is responsible for providing health care to roughly 1 in 38 Americans, or 1 in 32 Americans with health insurance. Small businesses are an important part of our program's membership. In most of our regions, groups with less than 25 members make up the majority of our enrolled groups.

About 225,000 individuals are enrolled through groups of 25 or fewer. Another 5 percent of our membership is comprised of direct pay members, many of whom we believe are employed in businesses that do not offer employer-sponsored coverage. Almost 9 percent of membership in the Ohio region is from small employers.

Furthermore, we see small groups as an increasingly important factor in our future growth. In fact, in some of our older regions, small group membership growth is more rapid than in larger groups.

In northern California, for example, in the past year, approximately one-quarter of our growth has come from groups with under 100 members, 12.5 percent from groups of 25 members or fewer.

As a matter of policy, we want potential members to have the option of enrolling with an alternate carrier. However, in recognition of the fact that small employers are finding it increasingly difficult to find affordable and reasonable health benefit options because of age-rated premiums, medical underwriting, less than comprehensive benefits and the like, and because many carriers refuse to be offered to small groups under a dual choice arrangement, we often waive our dual option rule and become the only plan offered in a small group.

In our northern California region, we do not require dual choice for members of groups of less than 50 employees, although we have established a minimum number of 5 subscribers in groups of less than 25 employees and require employers to make a contribution of at least 50 percent of the premium.

Most of our other regions do not require dual choice for groups with 25 employees or fewer.

Our Ohio region has had a long standing commitment to providing coverage to small employers. With over 17,000 members in this category, we have developed a small business health benefits plan specifically for companies with two to nine employees.

An example of our continuing commitment to small employers is our relationship with the Council of Small Enterprises of Cleveland, better known as COSE. COSE is the small business division of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce.

We began making our health benefits program available to small business affiliates of COSE in 1978. In 1989, we added an insured dental program as part of the benefits available to COSE affiliates. There are currently over 600 companies representing over 3,200 members served by Kaiser Permanente through COSE.

Approximately 500 companies that had been served through COSE dropped that affiliation when COSE imposed an administrative fee on its services. We now provide health benefits to those companies directly.

Kaiser Permanente Medical Care Program grew by 614,828 members in 1989. Program growth could have been at least 10 percent greater than it had been the previous year if we had not taken steps to limit our growth in the second half of the year. Nine of the twelve regions completely or partially closed enrollment of new individual members and/or new groups. In Ohio, the addition of new groups through COSE was the last to be discontinued.

We experienced extraordinary membership growth in Ohio as well. In 1988, we forecasted and planned for a membership growth of 9,228 members. Actual growth was twice that. For 1989, we forecasted and planned for growth of 12,000 members and enrolled 9,000 in the first 2 months. We immediately implemented proce-

dures to slow our growth, but continued to make new group enrollment available to affiliates of COSE, as well as the Better Business Bureau and the Akron Board of Trade.

By May of 1989, the membership growth was 13,500, and in June we closed enrollment to all new groups for the remainder of the year. We did permit all existing COSE groups to add employees to their Kaiser Permanente coverage during their open enrollment period, in July and August.

In Ohio, when we lifted our moratorium to new group enrollment, one of the first groups to which we opened enrollment was COSE. We are very much concerned, as you can imagine, by public statements COSE made in testimony last summer before the House Small Business Committee regarding our relationship.

One of these was to the effect that, when their other carrier proposes to reject an employer's entire group because one member has a serious preexisting medical condition, COSE suggests that the individual member enroll in COSE's federally qualified HMO. Kaiser Permanente is COSE's federally-qualified HMO.

In effect, therefore, COSE is aiding and even encouraging their other carrier to health screen and discriminate against small employers because of the health status of one member in the group.

Kaiser Permanente provides comprehensive basic health services for members, including members of small groups and individuals without imposing any deductibles, and with very limited copayment requirements. We do not apply medical underwriting to our group membership. We have established a policy under which all groups of 100 or fewer will pay rates which do not exceed the region's community rate.

Our experience to date in providing coverage to members of small groups indicates that their average utilization of services does not differ materially from utilization by members of larger groups.

But if we suffer adverse selection in the small group market because of the practices of other carriers, it will make it more and more difficult for us to keep our plan affordable for small groups and may make it necessary for us to reexamine our rating policy.

Thank you for the opportunity to share our views with you this morning.

Mr. Fleming and I would be happy to answer any questions you might have.

[The statement of Ms. Paul follows:]

TESTIMONY OF KAISER PERMANENTE MEDICAL CARE PROGRAM
ON HEALTH INSURANCE IN THE SMALL GROUP MARKET
BEFORE THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

April 3, 1990

Mr. Chairman, and members of the Subcommittee, I am Kate Paul, Vice President and Regional Manager of Kaiser Foundation Health Plan of Ohio. I am accompanied today by Jerry Fleming, Director of Program Development for Kaiser Foundation Health Plan, Inc., in our Northern California Region. We are testifying on behalf of the Kaiser Permanente Medical Care Program.

Kaiser Foundation Health Plan, Inc., its eleven subsidiaries, Kaiser Foundation Hospitals and twelve independent Permanente Medical Groups comprise the Kaiser Permanente Medical Care Program. The Program is an economically self-sustaining organized health care delivery system that provides health benefits on a prepaid, direct service basis to more than 6,400,000 members in California, Oregon, Washington, Hawaii, Ohio, Colorado, Texas, Maryland, Virginia, Connecticut, New York, North Carolina, Georgia, Kansas, Missouri, Massachusetts, and the District of Columbia. The Program is responsible for providing health care to roughly one in thirty-eight Americans or one in thirty-two Americans with health insurance. Our Health Plan members receive services through twenty-nine of our own hospitals, more than 200 medical offices, more than 7,700 contracting physicians and over 66,000 employees.

Kaiser Foundation Health Plan, Inc, and its eleven subsidiaries are all federally qualified health maintenance organizations. We provide comprehensive basic health benefits to our members, including our members in small groups and our individual members, without imposing any deductibles and with very limited copayment requirements. We do not apply medical underwriting to our group membership.

Our Program has established a policy under which all groups of 100 or fewer members will pay rates that do not exceed a Region's community rate. This policy is intended to promote the affordability of coverage for small groups and is consistent with but more protective of small groups than the rating requirements of the Federal HMO Act.

Small businesses are an important element of our Program's membership. In most of our Regions, groups with less than 25 members make up the majority of enrolled groups. About 225,000 individuals are members of groups of 25 or fewer. Another five percent of membership is comprised of direct pay members, many of whom we believe are employed in businesses that do not offer employer sponsored coverage. Furthermore, we see small groups as an increasingly important factor in our future growth. In fact, in some of our older Regions, small group membership growth is more rapid than growth in larger groups. In Northern California, for example, in the past year approximately one-fourth of our growth has come from groups with under 100 members; 12.5 percent from groups of 25 members or fewer.

Because the small group market is so important to us, the various Regions of our Program have in place a number of initiatives to encourage the participation of new groups of fewer than 25 employees. Many Regions use telemarketing to

target small groups and dedicate health plan representatives full time to recruit small groups. Our Colorado Region has initiated a direct mail/telemarketing campaign aimed at small businesses with 25 or fewer employees. They expect to contact over 45,000 businesses in this category between now and June 1.

As a matter of policy, we want potential members to have the option of enrolling with an alternate carrier. However, in recognition of the fact that small groups are finding it increasingly difficult to find affordable and reasonable health benefits options because of age-rated premiums, medical underwriting, less than comprehensive benefits and the like, and because many carriers refuse to be offered to small groups under a dual choice arrangement, we often waive our dual option rule and become the only plan offered in a small group. In our Northern California Region, for example, we do not require dual choice for groups of less than 50 employees, although we have established a minimum number of five subscribers in groups of less than 25 employees and require employers to make a contribution of at least 50 percent of the premium. Most of our other Regions do not require dual choice for groups with 25 employees or fewer.

Our Ohio Region has had a long standing commitment to providing coverage to small employers. We have developed a small business health benefits plan specifically for companies with 2 to 9 employees. The plan has three levels of coverage, and dental coverage is available. In addition to the plans we make available to small businesses, we use a community rating methodology which pools all of the groups with fewer than 100 members. This pool is then adjusted for demographic factors to determine the overall rate. In no event does this rate exceed the Region's community rate. Next year when the Ohio Region implements adjusted community rating, we will follow Program-wide guidelines in establishing small group rates. These guidelines provide that groups with fewer than 100 members will have a rate that reflects a blend of each group's expected utilization based on its demographic composition and the pooled average utilization of all small groups. The rate will be capped at the Region's community rate.

A specific example of our commitment to small employers is our relationship with the Council of Smaller Enterprises (COSE) of Cleveland. COSE is the small business division of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce. We began making our health benefits program available to small business affiliates of COSE in 1978. In 1989, we added an insured dental program as part of the benefits available to COSE affiliates. There are currently over 600 companies, representing over 3,200 members, served by Kaiser Permanente through COSE. Approximately 500 companies that had been served through COSE dropped that affiliation when COSE imposed an administrative fee on its services. We now provide health benefits coverage to those companies directly.

The Kaiser Permanente Medical Care Program grew by 614,828 members in 1989. We are forecasting growth of 450,000 members in 1990. This record level of growth confirms our belief that we are a health care program of choice in an increasingly sophisticated and competitive marketplace. This level of growth is a challenge to a prepaid group practice plan. Every additional 100,000 members means nearly 40,000 more annual days of hospital care, 350,000 more annual visits to physicians in their offices and 1,400 more births a year. Every additional 100,000 members also means increasing the Program's health care resources by 125 physicians and 1,000 nonphysician employees, and investing another $150 million in new and expanded health care facilities and equipment.

Program growth could have been at least ten percent greater than it was last year if we had not taken steps to limit growth in the second half of the year. Nine of the twelve Regions completely or partially closed enrollment of new individual members and/or new groups. In the Ohio Region, the COSE small group enrollment was the last to close.

We experienced extraordinary membership growth in the Ohio Region as well. In 1988, we forecasted and planned for a membership growth of 9,228 members; actual membership growth was twice that. For 1989, we forecasted and planned for growth of 12,000 members and enrolled 9,000 in the first two months. We immediately implemented procedures to slow our growth, but continued to make enrollment available to affiliates of COSE, as well as the Better Business Bureau and the Akron Board of Trade. By May membership growth was 13,500, and in June we closed enrollment to all new groups for the remainder of the year. We did permit all existing COSE groups to add employees to their Kaiser Permanente coverage during their annual open enrollment period in July and August.

The Program's experience to date in providing coverage to members of small groups indicates that their utilization of services does not differ materially from utilization by members of large groups. It appears that in some Regions small groups are lower risks than the community average while in others they have the same or a slightly higher risk than average. We are very much concerned, however, about what our cost experience with small groups may be in the future.

The extent to which other carriers abandon small groups, aggressively underwrite, and require higher deductibles, co-insurance, and copayments threatens the continued availability of affordable health insurance coverage to millions of Americans. The disparity in underwriting practices also may threaten our ability to continue to provide affordable coverage to our membership as well as to this vulnerable group of members. For example, in our Mid-Atlantic States Region, we have been included as an option for employers with five or fewer employees through the Small Business Service Bureau. In 1989, the Region froze enrollment for this group because we were being offered in competition with an age-rated premium plan. Nonetheless, we continue to permit subscribers to change enrollment status and add new spouses and children as members. Our enrollment level in this group remains at about 38 percent.

In Ohio, when we lifted our moratorium on new group enrollment, one of the first groups we opened enrollment to was COSE. We are very much concerned, however, by a public statement COSE made last year in testimony before the House Committee on Small Business to the effect that, when their other carrier proposes to reject an employer's entire group because one member has a serious pre-existing medical condition, COSE suggests that the member enroll in COSE's federally qualified HMO. Kaiser Permanente is COSE's federally qualified HMO. In effect, COSE is aiding and even encouraging their other carrier to health screen and discriminate against small employers because of the health status of one member in the group. Kaiser Permanente does not use health screening as a criterion for group enrollment nor do we disenroll groups or individuals because of their health experience. But if we suffer adverse selection in the small group market because of the practices of other carriers, it will make it more and more difficult for us to keep our plan affordable for small groups, and it may make it necessary for us to reexamine our rating policies.

As you know a great deal of work has been done by a variety of public and private organizations in designing proposals to make health benefits more available and affordable to every American. Most of these proposals extend, either by a mandate or voluntarily, private health insurance through the present employment-based structure. We endorse the strategy of utilizing the employer-based structure to the extent those without health benefits coverage are employed. We also recognize there must be another mechanism for those outside the workplace.

We have studied a number of proposals and in our California Regions we recently joined with others to fashion a plan that, if implemented, would expand the availability of health insurance to small employers.

To the extent employers, particularly small employers, are strongly encouraged or required to provide health benefits coverage to their employees and dependents, one approach, which holds promise for making small group coverage more available and affordable is the guaranteed enrollment model, a variant of a proposal that is being considered in California.

Guaranteed Enrollment Model

- All carriers participating in the small group market would be required to accept and guarantee renewal of health benefits coverage.
- The requirement to provide guaranteed enrollment should recognize the capacity limits of prepaid group practices such as the Kaiser Permanente Medical Care Program and other direct service plans.
- Carriers should not be allowed to utilize underwriting rules, such as limitations on coverage for pre-existing conditions.
- Benefits should be adequate and shifting costs to health care consumers through the use of deductibles and co-insurance should be limited.
- The design of health benefits coverage should be to encourage community or similar rating methods so as to responsibly spread the risk across as large a population as possible.
- If the plan incorporates reinsurance pools, participation in the pool should be voluntary. Small group carriers that do not participate in the reinsurance pool should be required to assume the full risk of enrolling small groups.
- Contributions to cover pool losses should be covered by assessments on carriers participating in the pool, and on health benefits plans that are not part of the small group market.

We hope to continue to work with others in the design of programs based on this and other models to make health benefits coverage more available and affordable to small groups.

Thank you for the opportunity to share our views with you. We will be happy to answer any questions you may have.

Chairman STARK. Thank you.

Ms. DiMarco, what's the cap that you mentioned for your program?

Ms. DIMARCO. It's $50,000 per year, per individual.

Chairman STARK. Any idea of how often that is exceeded?

Is that a very small percentage of your total Blue Cross and Blue Shield enrollment in Virginia?

Ms. DIMARCO. The number of times that that might be exceeded would be very small, in terms of incidents maybe 1-2 percent.

Chairman STARK. What's the theory that those folks go under Medicaid if they can't afford the additional cost?

It seems to me once you cross the $50,000 mark, you are apt to go into the stratosphere; I mean, $100,000 is the next stop on the line.

Is that just left to the community?

Ms. DIMARCO. Again, we had to balance providing some needed health care coverage with catastrophic coverage. We made the decision that most of the needs of the majority of the population could be met by having front-end coverage as opposed to limiting coverage up-front and providing catastrophic benefits on the back end.

Chairman STARK. Carl, about this coinsurance suggestion that the health insurers are making, let's see if I understand.

You guys want to run a risk pool, so you create some kind of an organization if one isn't there now.

Mr. SCHRAMM. A reinsurance mechanism.

Chairman STARK. Yes.

Then everybody who decides to reinsure, each insurer could make this decision so that they will have to medically underwrite in order to know who to put into the pool.

Then the pool is going to charge each of the small group insurers only, to begin with——

Mr. SCHRAMM. Yes.

Chairman STARK [continuing]. A couple of percent on all their premiums. They are going to have a premium tax, in effect, on the small insurance group. And if that isn't enough, you are suggesting that you go on to charge a percentage to all group insurance.

Now, let's suppose that insurance company A doesn't have any small group folks in there. Do they have to pay on their large group policies as well?

Mr. SCHRAMM. Yes, of the small group market contributions are insufficient.

Chairman STARK. And you are going to do this voluntarily?

Mr. SCHRAMM. Yes. Well——

Chairman STARK. OK. I'd say, good luck. By then——

Mr. SCHRAMM. Mr. Stark, let me be very clear. We are going to have to have a statutory enactment to establish this.

Chairman STARK. A Federal statute?

Mr. SCHRAMM. Well, it may be Federal; in Connecticut we will proceed at a State level.

Chairman STARK. Well, what if it's so you could do it a State at a time?

Mr. SCHRAMM. Yes.

Chairman STARK. You've heard the testimony earlier that in effect redlining goes on rampantly in the health insurance business, as it does in banking or anyplace else.

I don't think that any of us think that it doesn't go on.

Also you can do creative advertising. I would like to suggest that cigarette companies and the beer companies do so in a positive fashion. That is they advertise in such a manner to hook certain groups of people on tobacco or alcohol, and I would presume that you could do it the other way. You could avoid having people apply or respond to your ads by subtly designing your advertising campaign so that the people that you don't want don't respond.

Aren't you just kind of compounding this whole problem within your whole industry? Aren't you really opening it up to say that the really bright insurance company can avoid taking on a lot of risks that it doesn't want. Do you get one company that suddenly goes out and gets all the bad risks, dumps them in a pool, and makes a profit?

I'm afraid that you are just going to create gaming within the industry, and we are going to end up with the same problem that we already have.

Mr. SCHRAMM. Well, let me say that from the outset——

Chairman STARK. Let me suggest the other alternative. If we did away with medical underwriting, then you wouldn't need the risk pools.

Mr. SCHRAMM. Well——

Chairman STARK. Right?

If there is no medical underwriting, if you can't do it, then everybody's in the risk pool in proportion to the number of the risks they insure.

Mr. SCHRAMM. The industry is trying to balance two different interests. If we do away with medical underwriting altogether, we may in fact precipitate an availability crisis, that is, people leave the market altogether.

Chairman STARK. That's happened in the small group business already.

Mr. SCHRAMM. Right.

And this is exactly why we have formulated the proposal we have in front of you today. It might be helpful just to talk a little bit about how it is we envision the reinsurance mechanism operating, because it essentially exists to avoid the problem that you ask about.

Now, if I'm a small group insurer, I am essentially bound to operate in this market and to offer this product.

And I have to offer that product within the rate boundaries that I talked about. I have to do it without the operation of preexisting conditions, and I am also bound in renewal periods by rate corridors.

Now, in order to make that operate, we have to offer protection to the insurance company, and the insurance protection that we have offered is the establishment of a reinsurance mechanism. We believe that the sine qua non of making our companies operate within these new regulatory guidelines to make sure insurance is affordable.

The question of medical underwriting is a question of balancing the risks. We need that in order for the company to make a determination as to whether or not to cede the risk on a high-risk individual.

Chairman STARK. To which?

Mr. SCHRAMM. On a high-risk——

Chairman STARK. What did you say before?

Mr. SCHRAMM. I'm sorry. We need medical underwriting, I said, to allow the company to cede the risks—C-E-D-E—the risks into the reinsurance vehicle.

The purpose of that is again, as I said in my opening statement to identify reinsured individuals, who would not know they were reinsured. The employer who purchased the plan would not know that either. Reinsurance operates as a protection for the insurance company anticipating that there might be a particularly high cost.

And also because——

Chairman STARK. Let's stop right there for a minute.

Let's assume for a minute that you didn't separate small and large groups, except for sales costs. Would you change the requirements to say that anybody who wants to sell any kind of insurance in a State sells it all, from 1 to 10,000?

Mr. SCHRAMM. Yes.

Chairman STARK. Then, if you prohibit medical underwriting and you have some kind of either a subsidy or a mandate so that you are beginning to get more and more people in the pool, why won't the industry itself become its own self-insurer?

Why doesn't this high-risk individual become just part of the actuarial odds?

Mr. SCHRAMM. The structural problem is called size of insurance company. Each company manages its own pool.

Chairman STARK. Yes.

Mr. SCHRAMM. Now, if we didn't have some small and medium-sized companies, perhaps what you said would operate. OK. That is, the pools managed by any given company would be large enough to handle it.

Chairman STARK. OK, but it seems to me to be the same as life insurance. You've got a small company; they have got to lay off enough of their book in the reinsurance market to deal with their capital, and so they put a cap on their benefits.

Mr. SCHRAMM. Yes.

Chairman STARK. They reinsure everything in the reinsurance market with bigger insurance companies. They still don't need to just reinsure the high-risk individuals; they reinsure the whole book.

That solves your problem, doesn't it?

Mr. SCHRAMM. Well, again, life insurance is really quite different from health insurance in that regard.

Chairman STARK. No, but I'm saying this could even work with medical insurance. Somebody's only got $3,000 to $5,000 insured. They could say, "Wait a minute, I don't have much capital, and therefore I'm going to put a cap, reinsurance-wise, I am going to cede everything over $10,000, and I am going to go buy it in the reinsurance market."

They still have a pool, and it still fits into a pool, though this is purely theoretical; I'm not so sure that rather than go through all these steps that you want to go through that you can't get to the same place with Federal risk pools.

You are going to have to have a law to collect. You are going to have to force everybody to pay this premium tax. It sounds a little bit to me like you are jumping through a lot of hoops, but let's make it free enterprise, although you are really going to need an awful lot of laws to get these free enterprisers into the box.

Mr. SCHRAMM. Let me try a different answer.

Chairman STARK. All right.

Mr. SCHRAMM. I have heard a lot today about community rating. My vision of community rating is that it effectively stopped operating about 40 years ago when we got about 20 percent of the population covered with health insurance.

What is being attempted through community rating is to step back in time where a company, regardless of size, when it sold a health insurance contract to Joe's Sunoco with 10 employees, essentially kept the risk in-house; it managed its risk.

Our proposal essentially attempts to do that, that is, the rules that we have established to get into the reinsurance mechanism are set up such that there is a very strong incentive, if you are the originating carrier, to keep that risk inside.

Under our proposal, reinsurance of individuals would generally be on a 3 year basis. Initial placement would be for 3-year periods. You can't comb your book of business to keep ceding risks individually as they turn sour; and the premium to enter is about 500 percent of the market costs of that, so you have to make a very careful decision as to what you expect you are going to lose in terms of covering an individual.

Now, you may say that that looks like a lot of hoops to avoid Federal legislation. That focuses the question specifically on whether or not we ought to avoid Federal.

And I think it is——

Chairman STARK. You have got it in your plan as a last resort. First, it goes on in the small group market, and then it goes on in the large group market, and I can see that there is a wonderful lawsuit there.

If I'm an insurer, and not taking small groups, and you want to clip me 2 percent to fund your pet project, believe me, I am going to spend a lot of time in the courts before I cough up that much.

Then, if that isn't enough, you say you need a Federal subsidy to pay for it.

So, basically you see us here funding this pool as kind of the last resort, and I'm saying why don't we get together and just start out designing this pool from step one, and then we'll get Kaiser in the box with us as well, and everybody will pay a little, and it will be there.

Then we can do away with medical underwriting.

Mr. SCHRAMM. Well, now let me approach the whole question of——

Chairman STARK. Just a thought.

Mr. SCHRAMM. —of how we are going to fund that.

And that is, essentially, we don't envision a lot of lawsuits. We believe that we have reached the treaty within the house of insurance that we would like to give effect to enshrined in law.

Ours are companies run by individuals who the record will show don't go around suing each other over reinsurance issues. I think

our latest and our best example is the case of the Baldwin United bailout where it was an industry internal bailout.

The second point in terms of when do we get the Federal funding. I should say——

Chairman STARK. Is that going to hold true for executive life? When the Judgment Day comes, are you guys going to be right?

Mr. SCHRAMM. I'd prefer not to talk about that, but, if I might, there are discussions to that effect inside the industry now.

The point I wanted to make with regard to the Federal funding is that we are embarking on an untried course. We think its design features will enable the industry to cover losses. We do envision that those operating in that market pay a premium tax of 4 percent to the pool, that the risk to that pool is kept very limited by the entry rules that we have established in terms of the 3-year period and the 500 percent premium for reinsurance, that the spread of that at the second tier, and a 1 percent premium tax over all carriers would generate certainly sufficient moneys to protect the pool. Under our offer, all of this would have to blow up before we would have to contemplate an appeal to Government for further funding.

Chairman STARK. Well, OK, if we have to help out—and grudgingly, the Federal Government doesn't like to interfere in private business, as you know—but if you beg us to get involved in the health insurance industry, by facilitating these pools, for example, I suppose we could pass some Federal laws requiring all the health insurance companies to participate, but, what are you going to give us in return?

Are you going to limit your profits? Or are you going to take some of your profit and invest it in low income insurance for low income workers? What's the quid for my pro quo here?

Mr. SCHRAMM. Well, the first quid is, the generation of all those reinsurance dollars in the reinsurance pool allows us to offer you a market that's been reformed, to make available coverage, and also, to some extent, to subsidize the coverage.

This is, as I said in my testimony, an attempt at affordable coverage, that is, it brings the upper boundary into play in terms of what a small employer will have to pay in the market for insurance, should he or she enter the market and seek to buy insurance.

I think those are two quids that are of consequence in the give and take of private and public responsibilities.

Chairman STARK. But, now, Ms. Paul tells me she doesn't need that. She's doing all these wonderful things in Ohio already, for less than you guys are doing it, and she needs a little help to make sure that all the employees don't dump their high risks out of their group plans into her Kaiser Permanente plan. So my other alternative is just to suggest that rather than mandate insurance coverage, we should say that the whole medical care delivery system has to be an HMO. That would be all right with Ms. Paul, but your only worry, I take it, for the Kaiser Permanente plan would be some protection against the risk-dumping, in a sense, into your program.

Ms. PAUL. It is of great concern to us. We have many other concerns, however.

Chairman STARK. Well, you don't want us to not penalize you if you have to close down your enrollment because of capital limitations if you go too fast?

Ms. PAUL. Yes. We certainly have capacity issues that are worrisome to us.

Chairman STARK. What do you do about smokers?

Ms. PAUL. What do we do about them?

We enroll them.

Chairman STARK. Well, you have got to come to California. My mom still can't get in, you know, because she smokes, but I want to talk to you about that later.

Blue Cross has just decided to do the right thing, and I have been led to understand that 8 or 10 plans across the country will offer these kinds of restrictions, no medical underwriting, no previous conditions, etc., etc., etc.

What they want back is an exemption from taxes. I have heard from one Blue Cross plan that tells me that this is sheer nonsense, and that this is a plan for 8 or 10 good-guy insurers, as I call them, to absolutely go broke.

This person insisted to me that Empire and whomever else is doing this—there is one in Pennsylvania that's doing it, that it is sheer madness, that they just absolutely have to go broke.

What does Blue Cross say about that? Have you designed a scenario for disaster?

Mr. TRESNOWSKI. No, I think I know the individual you are talking about, and that particular market is really quite different than the 8 or 10 Blue Cross and Blue Shield plans that we are talking about because they have certain opportunities. First, they have a large market share, so they have a large risk pool. Second, they have been able to negotiate reasonable provider differentials. Because of these factors, they are not going to go broke.

I think the important thing——

Chairman STARK. No, no, this person is saying that he isn't going to go broke because he isn't going to get into that situation.

Mr. TRESNOWSKI. I understand. I'm saying that those 8 or 10 plans aren't going to go broke because they have got the business facility to be able to do those sorts of things.

But, more important than that, as I've told you in another circumstance, it stands as a standard, and incentive, that any organization in this business ought to look to, in weighing how it conducts its business. That's the important thing to me, that we have in Federal law some kind of a standard that serves as an incentive for organizations.

If I may just comment on Carl's notion here, we are pleased with what the HIAA has done. They have taken a step in the right direction. We view it as only a step, though. We are pleased particularly with the open enrollment part of it. That's extremely important—open the doors to whatever the risks may be. However, there are some specifics that I would really need to talk to the HIAA about.

The other thing that's important is the rating bands, the narrowness of the rating bands so that you have affordabiltiy.

Our major concern is the one that you were discussing, Carl, and that's the reinsurance mechanism. As I understand the proposal,

everybody that sells to small groups fall into the reinsurance pool. That would disadvantage us significantly because we carry a higher percentage of substandard risks, plus we have a bigger volume of business.

So, first, we would be taking the bigger risk right up front, and, second, we would be subsidizing and financing the pool to a greater extent than everybody else. In other words, we would be double-dipped in the situation.

I like your idea where the carrier takes its risk all by itself, and then it makes a judgment on how much of that risk it lays off on a reinsurance mechanism. There are private reinsurance mechanisms today that can accommodate this. That's our big concern about the proposal.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Ms. DiMarco, did Virginia pass legislation that enabled Blue Cross to come up with this program for smaller employers?

Ms. DIMARCO. Yes, it did.

Mr. CARDIN. And what did that legislation provide? Did it mandate some of the things that you are required to do in offering your plan?

Ms. DIMARCO. Yes, it mandated certain benefit provisions, like preventive care, and maternity care. It also mandated that it would be an open enrollment product. There would be no red-lining, and that it would be available to employers up to 50 lives.

Mr. CARDIN. So the parameters are determined by State law, and of course, the tradeoff is that the mandates for insurance have been relaxed.

Ms. DIMARCO. Yes, the mandated benefits and mandated providers have been removed totally for products meeting these guidelines.

Mr. CARDIN. Now, did you initiate that legislation, in the Virginia Legislature?

Ms. DIMARCO. Yes, we did.

Mr. CARDIN. Has that been the pattern that has been followed in these 7 or 8 other examples of Blue Cross innovative programs for small——

Mr. TRESNOWSKI. At the present time there are only two States that have done what Virginia has, and that is Virginia and the State of Washington.

In both cases, Blue Cross plan, generated the legislation, and in both cases they have responded with the kinds of products.

Mr. CARDIN. Do you envision that more State legislatures are going to be taking this up?

Mr. TRESNOWSKI. I think the important thing is that they are beginning to understand the relationship between mandated benefits and cost and affordability.

You know, there are States that mandate wigs and a whole lot of other benefits, that just simply add to the cost of the benefits.

Chairman STARK. Would the gentleman yield?

Mr. CARDIN. I would be glad to yield.

Chairman STARK. Aren't the only major costs in substance abuse and mental health? Aren't they a large part of these additional benefits?

Mr. TRESNOWSKI. There's a 20 percent factor, and about half of it is made up of substance abuse and mental health. It depends really upon the benefit design.

Chairman STARK. How the mandate is written.

Mr. TRESNOWSKI. My sense is that the wigs and some of the other mandated benefits is subterfuge, the real issue is the big cost item: substance abuse programs and mental health benefits.

Chairman STARK. That's a big factor, yes.

Mr. TRESNOWSKI. Yes.

Mr. CARDIN. And in the Virginia statute that has been modified in those two areas?

Ms. DIMARCO. Yes, that's right.

Mr. CARDIN. And here in Washington, I take it that substance abuse and mental health also are modified, as the tradeoff. So, that's been the real tradeoff as far as being able to offer a package that's less costly.

Now, do you think other States will be moving into similar directions?

Mr. TRESNOWSKI. Yes, as they come to the realization that there is that opportunity to affect the affordability of the product.

Mr. CARDIN. It seems like that in Virginia and in Washington the Blues initiated the change, and I'm wondering whether the Blues in other States have started the process to initiate the legislative authorization to try to help solve the problem of small employers' access to insurance.

Mr. TRESNOWSKI. Every State has got its own sort of strategy at the moment. You've got Oregon with its kind of strategy; you've got Colorado moving in this general direction.

You get to the Midwest and the Northeast, you don't have the need for that because Blue Cross and Blue Shield plans have enjoyed a large pool, a large market share, if you will, plus they have been able to negotiate effective provider discounts which gives them another form of subsidy that can make these products affordable, so every environment is different. A combination of factors contributes to the affordability of the product.

Mr. CARDIN. Carl, let me just ask you one question.

First, I want to thank you for the comprehensive approach that the industry has taken in trying to come up with more availability of insurance for smaller employers by meeting some of the major problems that have been presented to this committee and to Members of Congress.

As we talk about the reinsurance issue, is there any mechanism in place where you have reinsurance on health risks?

Mr. SCHRAMM. Currently?

Mr. CARDIN. Yes.

Mr. SCHRAMM. There is a private reinsurance market in place, Mr. Cardin.

Mr. CARDIN. But that's not working adequately?

Mr. SCHRAMM. Well, it is essentially designed to meet strictly a commercial interest. What I have testified to today meets a commercial interest that is driven out of a social policy interest, if you will.

We propose a nonprofit, reinsurance mechanism to reduce the cost further, and it would operate essentially as backstop financing

with specific rules that would be focused on individual reinsurance. Statutory premiums to enter and statutorily set 3 year windows of availability.

Mr. CARDIN. If I am a large employer and have insurance through a large group plan, it seems to me that there might be some incentives for me to try to get my high-risk people into a small insurance employer plan.

And if I have the flexibility to have more than one insurance plan, that maybe if I steered high risk employees into a plan that's covered under reinsurance, it may save me some money.

Is that a justified fear or not?

Mr. SCHRAMM. I really don't think so. Principally, the discipline of the market operates such that there is such an efficiency in insuring all your employees, the largest possible group, that that would far offset any efficiency you might get by targeting specific high risk individuals and seeking to reinsure them through a small group so that the carrier could then seek reinsurance.

Mr. CARDIN. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I thank you, Mr. Chairman.

Ms. DiMarco, in designing your plan—first of all, let me congratulate you on designing a product in today's environment that is affordable.

I have two questions about it. First of all, have you and has Blue Cross considered some kind of reinsurance mechanism over that $50,000 cap, or maybe over the $100,000, or maybe over the $150,000. Now, what would that add to your cost, particularly, if you left some gap between the $50,000 and some higher level? But so that we could avoid what the chairman referred to, of a $1 million cost reverting to a hospital and being absorbed by the public.

Did you consider a reinsurance mechanism as capping also the losses?

Ms. DIMARCO. Yes, we did, and I'll give you precise figures as to what it would add to the cost, but it was significant enough that we decided that that would produce a price that would not be affordable.

Chairman STARK. Would the gentlelady yield to me on that point?

Mrs. JOHNSON. Yes.

Chairman STARK. I was going to ask that same question in a sense. I have always thought—and maybe I was wrong from the beginning—that the catastrophic benefits were the least expensive to insure, and that it is the long-term care benefits that get very expensive. I would love it if you could come up with some numbers and can get them to us later.

For example, what do you estimate that it would cost in Virginia?

Just to insure everything over $50,000.

Thank you.

Mrs. JOHNSON. And would you also in giving us those figures give us some other figures. What would it add on if you got reinsurance for everything over $100,000, over $150,000, over $200,000?

Because one public policy question is how much can we allow to be risked out there by someone who obviously can't repay, for the

purpose of day-to-day low cost? But those very, even if the whole amount doesn't cost over $50,000. There might be something in there that would at least stop the gigantic losses and then leaves us a different kind of problem.

So, if you would give us those that would be interesting.

Then, did you look at mental health care, because in Connecticut we didn't look at it with the tremendous help of the HIAA in Connecticut in support of the Blue Ribbon Commission.

One of the plans that they came up with provided some minimal mental health opportunities so that all of that, in a sense, could be perceived as preventive mental health, that prevents marriages from breaking up, and that helps people get over rough times and build a more solid base in their lives.

At fairly low cost and very important to preventing larger problems later on mental health care was built in to one of the alternatives, without a great deal more expense. I think there was a 10 percent difference in the premium. And I wondered if you investigated any core program that also had some kind of mental health and substance abuse program in it.

Ms. DiMarco. In Virginia, the current mental health mandate is 30 days in-patient care, and $1000 outpatient care. If we had included both of those, it would have added approximately 14 or 15 percent to the premium.

Mrs. Johnson. But your whole program goes around the mandates of Virginia, so did you look at any lower level of care, lower than the mental health mandates in Virginia?

Ms. DiMarco. No, we did not.

Mrs. Johnson. Perhaps you could do that, and see what it would add on to your costs, to have some mental health package. We could give you the example from Connecticut or perhaps Mr. Schramm is familiar with that and could give that to you?

Ms. DiMarco. The other thing in Virginia that was considered though was that the public health system provides for mental health care outpatient through a series of mental health clinics in Virginia.

And that is what we had proposed for mental health care for this.

Mrs. Johnson. I see.

Mr. Schramm, in regards to your reinsurance mechanism, would self-insured companies have to participate in that? Would the Government participate in it for Medicaid, you know for any of that Medicaid buy-in population?

Mr. Schramm. Mrs. Johnson, this is still evolutionary, and we have both questions under consideration. I can't give you a hard answer on either of them.

Mrs. Johnson. I am interested that you supported, indeed helped Connecticut work out a program that addresses many of our concerns and restrictions, and determinations, and coverage and the problem of preexisting conditions in a number of those things.

You also did work out the core benefit plan proposal in some detail, and we certainly have heard here today how important preemption is to controlling costs.

Where is that core benefit discussion in Connecticut?

Mr. SCHRAMM. I believe it is right now in the legislature in Connecticut.

Mrs. JOHNSON. I know the bill is; my sense is, but I'm not sure, that competition comes later on, whether to find a core benefit, or whether to negotiate subsidized prices with providers or some kind of cut-rate prices with providers, which if everyone does, has long-time implications that are fairly hostile to the survivor of high-quality providers.

My recollection is that provider negotiation has been the preferred choice in the Connecticut discussion although it is not firmly resolved, rather than making some of the difficult decisions about the core benefit plan.

Mr. SCHRAMM. Yes, I am afraid that I just can't speak to the details of the status of exactly those discussions are right now.

Mrs. JOHNSON. I thought you had been more closely involved than that. That is my understanding and that is a problem.

In Kaiser's case, because you do offer a different program, you are outside the State mandates, are you not?

Ms. PAUL. In the State of Connecticut?

Mrs. JOHNSON. In any State.

Ms. PAUL. By and large, we are required to comply with the State mandates.

Mrs. JOHNSON. And is that one reason why you haven't been very successful in the Northeast?

Ms. PAUL. No.

Mrs. JOHNSON. I'm not saying Kaiser, but HMOs in Connecticut have not been successful, and I am wondering if that is the cause.

Ms. PAUL. No, I don't think so, and I don't know that I would agree that we have been unsuccessful. We have grown rapidly in the Northeast, and we want to manage that growth consistent with our capacity to provide that care. We are quite satisfied with our Northeast operation.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Carl, just a couple of other questions, and you could respond to this at some other time. I don't mean to be obtuse, and subtlety has never been one of my egregious faults, and I can't articulate it very well, but maybe you can stew on this and we can talk about it another time.

I have no quarrel with risk pools, or anything else, but what I am basically seeing is that you can't do it without the Federal Government, or perhaps the State Government, but more realistically the Federal Government.

Yet you don't want to do it with us. What I am reading into that is the same old design. It's business and the U.S. Chamber of Commerce, all getting together and saying, we don't really want to admit that we should deal with the Federal Government. But maybe I'm misreading it.

It sounds cumbersome to me, and it is more than likely because I don't understand it thoroughly, but I'd like to say, that the health insurance industry is moving with great strides in the right direction.

But there is something in that that says we could do that better, and do it quickly and more easily than the way you are suggesting.

I'd like to just reexamine that issue sometime.

Mr. SCHRAMM. I'd be happy to meet with you and reexamine it. I just want to say going into this, that while we do share a cultural value that says we have a pluralistic financing system, that is one that is publicly and privately financed, we prepared to move reform ahead for the private side of the equation.

We have sought, and will seek, Government action, as we have in Connecticut and will elsewhere, because we believe that is necessary to give life to the proposals we have made, but we have to appreciate, it seems to me, that the reach of these proposals is pretty grand. We have never engaged in a discussion that would go so far in fundamentally reforming past practices, and we will seek Government action, as I say, to give life to the scheme we have created here.

Chairman STARK. Did you participate in the Connecticut plan? Your industry, or your association?

Mr. SCHRAMM. Yes.

Chairman STARK. Well, I'm reading something here but I'm not sure what it is. I guess it is a report from Lewin.

It says "Insurers are to be prohibited from using medical underwriting to exclude individuals from a group." But they wouldn't, I gather. Then what it doesn't say is that they wouldn't be prohibited from using medical underwriting to set rates and decide who ought to be ceded to reinsurance. Is that——

Mr. SCHRAMM. That is right.

Chairman STARK. That's what's missing in that question?

Mr. SCHRAMM. Yes.

Chairman STARK. One other question: we have heard eloquent testimony here to the effect that Kaiser is able to do this at a lower cost than the private insurance industry, and do all of the socially proper things, and one of your more prominent members advertises time and time again that if you sign up with them, part of their service, in addition to paying the agent's commission, is to help on cost savings; and I would suspect that many of your larger members have their own HMOs.

Now, why can't they do what Kaiser does when here you've got private insurance and the best minds that private enterprise can hire and they have started their own HMOs. Why can't they do what Kaiser does?

Mr. SCHRAMM. Namely?

Chairman STARK. Namely, provide no medical underwriting, open coverage, at much lower costs than the private insurance company and all the things we are striving for, taking individual members, small groups at the same rate you charge larger groups, or at no more than the community rate?

Why can't private insurers do this?

Mr. SCHRAMM. Well, I think in time we might. Our historic experience with HMOs is part of our approach. To be perfectly frank with you that relates principally to our larger group customers through a number of our members are currently providing coverage of small employer groups through HMO's and other managed care plans. Much of what we do with larger group customers looks

exactly like what Kaiser does, in terms of efficiencies, lower costs, and so forth.

Chairman STARK. Yes, but you're not providing that one missing link, which we all agree can be more expensive and more problematic, and that is the individual policy in the small groups, which is the topic we're here to discuss today.

Mr. SCHRAMM. Our biggest problem at the moment is focusing on the solution and rectification of problems in the small group market.

I think a second question is, once we get these folks in, we will in fact see something very positive happen, and that is, enlarged capacity in the private marketplace; that is, carriers will enter to assume more active roles in the small group market, and many of those carriers, in fact, are carriers that have a substantial stake in the HMO delivery.

But the other smaller point is, I think, and you may speak to this from Kaiser, the Kaiser reach isn't to individuals with the HMO situation, if I've understood your testimony correctly.

Ms. PAUL. That we reach some individuals?

Mr. SCHRAMM. Yes.

Ms. PAUL. You mean, do we cover individuals?

Mr. SCHRAMM. Right. Individual cases.

Ms. PAUL. Yes, we do.

Mr. SCHRAMM. One person shows up.

Ms. PAUL. Yes.

Mr. SCHRAMM. All right.

Chairman STARK. Oh, yes, that's what I'm saying; that's what your HMOs don't provide. And, why not? Kaiser isn't going broke, they're expanding. What are they doing that CIGNA isn't?

Mr. SCHRAMM. As I say, I think my answer encompasses our historic commitment to the federally qualified HMOs. It's generally with larger group customers; it's a second generation, after these reforms were enacted. I think it's very likely to expect that individuals in small groups will find themselves able to access HMO delivery and HMO financing.

Chairman STARK. I think you're missing the question.

Mrs. JOHNSON. Mr. Chairman.

Chairman STARK. Yes, Mrs. Johnson.

Mrs. JOHNSON. Could I ask a question of you?

My understanding of Kaiser is that it's institution based, that it's an HMO, not a PPO. Now, has it changed?

Ms. PAUL. No, it hasn't. I think for the sake of clarification, it's more helpful to think of this as a prepaid group practice, in that we are essentially a prepaid mechanism for the delivery of care through the use of a group of physicians who are organized to deliver care to our members.

We are an HMO, technically, yes, that's correct.

Mrs. JOHNSON. But do you allow participation by individual physicians and providers in a community?

Ms. PAUL. No, ma'am. We contract exclusively with a singular medical group that either provides or arranges care for our members.

Mrs. JOHNSON. The reason I raise this issue, Mr. Chairman, is because doesn't this bear on this issue of individual access?

In other words, if you have a program set up and anybody nearby can participate, it doesn't matter to you too much whether you have a group or that individual; whereas if you're insuring in the common sense, in the other market, you have much less control.

Chairman STARK. Well, all I was suggesting, if the gentlelady will yield, is that there are large insurance companies that operate HMOs; but those HMOs don't take individual members, and they're not as low cost, and they don't take small groups.

Mrs. JOHNSON. I see.

Chairman STARK. And I'm saying, how come Kaiser can do it? I suspect the answer is that Kaiser's nonprofit, and has physicians on salary, and a whole host of other good things that allow them to provide care at more reasonable costs than some of the insurers who cling to age-old traditions, which don't seem to work in the 20th century, but that's purely a personal opinion.

Mrs. JOHNSON. You mean you allow patients a choice of provider, and the same provider, every time the same?

Chairman STARK. No, no, we're all talking about HMOs or special lists. I mean, there's no difference there. There are no easier rules in some than others.

I'm just suggesting there's a difference, and it's something that another time we might look at.

Could I ask the panel one——

Mr. SCHRAMM. Mr. Chairman.

Chairman STARK. Yes, Mr. Schramm.

Mr. SCHRAMM. I would just point out that Kaiser does this because it's the only thing Kaiser can do. Kaiser can't do anything else. They are an HMO; they have to do this.

And I want to say that I have member companies who already are serving small groups and that are absolutely intent on continuing to serve the small group marketplace within the HMO medium. Our experience in HMOs is not that long; it has been confined, for the most part, to the large group customers, but many of our companies have future business plans where the vast majority of all their covered individuals would be serviced through HMO and managed care networks, and in time, the unique manner in which Kaiser operates will in fact characterize a number of our member companies.

Ms. PAUL. Mr. Chairman? I'd like to add something.

Chairman STARK. Sure.

Ms. PAUL. I don't know if it's accurate to say that it's the only thing that we can do. It is what we have chosen to do, because we feel that it is the best way to deliver medical care to a broad population.

Chairman STARK. Yes, I might say, that in my experience, Kaiser in California, many, many years ago, was the first group to offer specialties in adolescent medicine, for example, and the first group in northern California to establish hospices.

So their creativity has tended to run towards social service to the community, rather than things like single premium annuities and tax shelter schemes and other wonderful things that many insurance companies are able to do.

So there are, I suppose, differences in what creative management will come up with, but I don't think that it's an answer, but it certainly sets a bench mark, it would seem to me, for others who want to provide care to all groups. They seem to have found the way, and I might add that Blue Cross/Blue Shield is running neck and neck toward the finish line, as they establish this criteria for the "good guy rating," as I call it, for those plans.

The Health Insurance Association, dealing valiantly with traditions that die hard, is trying to join the group, and doing a good job, and I look forward to working with all of you as we go down this road, to see what limited role the Federal Government can play in helping you.

Thanks very much for your participation.

The subcommittee is adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

[Submissions of the record follow:]

CIGNA Employee Benefits Companies

Hartford, CT 06152
(203) 726-4279

G. Robert O'Brien, CLU, ChFC
President

CIGNA

May 7, 1990

The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1114 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

I wanted to thank you for your positive reference to the Allied-Signal/CIGNA Managed Care program during the April 3rd Health Subcommittee hearing. We are very encouraged by the cost improvements we are seeing, not only on the Allied-Signal case, but on other CIGNA Managed Care accounts. We have made a major business commitment to reducing the rate of escalation in health care costs through Managed Care and it is beginning to bear fruit. I have attached a copy of a Fortune Magazine article which reemphasizes the growing market interest and high potential for Managed Care programs.

I also wanted to correct any misimpressions that might exist as the result of the response to your questions during the hearing. You asked Carl Schramm why CIGNA and other large insurers who operate HMOs do not cover individuals and small employers on the same basis as some other large HMO programs do? The fact is that we do!

With the recent acquisition of EQUICOR, CIGNA now operates 32 federally qualified HMOs, which must accept all applicants during group enrollment periods without regard to medical condition and at rates based on either a system of variable community rating or community rating by class. These are the very same conditions under which Kaiser or any other federally qualified HMO must operate.

Contrary to the prevailing view, we cover large numbers of small employer groups under our HMOs. Our records indicate that thousands of small groups are members of our HMOs and we cover more than 50,000 people under individual contracts.

Although we are reluctant to ask for Government action, the facts suggest that our health care system would benefit from legislative intervention. We would urge you to consider legislation which would make insurance more readily available to small employers. This would include legislation which would restrict the use of medical underwriting and rating practices that tend to limit access to coverage. You might also consider action which will make insurance more affordable to small employers. This would include (1) legislation that would assure that state legislative and regulatory actions do not inhibit or prevent the growth of cost reducing Managed Care programs; and (2) legislation to override costly state mandated benefits programs.

I would ask that this letter be made a part of the hearing record to clear up any misunderstanding regarding CIGNA's participation in the small employer health care market.

Sincerely,

G. Robert O'Brien

HIP

Health Insurance Plan of Greater New York
1150 Seventeeth Street, N.W. Suite 600
Washington, D.C. 20036
Telephone: (202) 659-9460

STATEMENT FOR THE RECORD

HEALTH INSURANCE IN THE SMALL GROUP MARKET

BACKGROUND

The Health Insurance Plan of Greater New York (HIP) is one of the nations oldest and largest non-profit prepaid group practice plans. Established in 1947, HIP serves nearly 900,000 members in the metropolitan New York area. Health care services are provided through over 800 participating physicians within more than 60 HIP medical centers, two of our own hospitals and an extensive network of hospitals, including some of the most prominent teaching institutions in the country.

With the acquisition of affiliate plans, our original New York base has expanded by an additional 175,000 members to include New Jersey and southeast Florida. HIP's Interplan program marks the beginning of an entirely new era, linking our affiliate plans to provide comprehensive HIP benefits to all members. Our Florida presence enables us tc provide full retiree benefits to members in the southeast portion of the state.

SMALL BUSINESS

Affordable health care is a national concern that touches upon small business in a unique way. Small businesses are faced with increasing demands to provide health care benefits, even though their resources are often modest.

One of the largest constraints small businesses face is the perception that because they are small they cannot obtain comprehensive health care services at a reasonable cost. The HIP Small Business Program was designed specifically to respond to this misconception. This program offers small businesses HIP's comprehensive health coverage at an afforable premium.

In 1988 we launched the Small Business Plan to provide hundreds of employers with health care benefits which they were previously unable to afford. These employers face the same pressures to provide health care benefits as their larger counterparts, but without the same resources. It is our intent to provide small businesses with the ability to meet those demands with a program that will not strain limited resources.

HIP'S APPROACH TO SMALL BUSINESS

The small business plan includes HIP's full range of comprehensive benefits with no deductibles and no copayments. The absence of out-of-pocket costs is consistent with HIP's philosophy that its members should not have financial barriers imposed which deter them from seeking necessary health services.

The premiums charged to small businesses compare favorably to indemnity coverage (attachment 1). These rates are in effect for small groups of 3-24 employees. No underwriting restrictions are included in these rates, i.e. no exclusions for pre-existing conditions, no waiting periods and no health screens for groups or individuals.

The absence of underwriting restrictions and the exclusive use of community rating is consistent with HIP's enrollment policies for large groups. To date, the utilization experience from small groups does not vary significantly from our overall community utilization rates. Current enrollment is 13,000.

The small group market is important to HIP and we are devoting substantial resources to market to these groups. A sample promotional flyer is attached (attachment 2). Telemarketing is the preferred technique due to the large number of potential accounts (over 30,000 groups) and the unique transportation problems of the New York City area. We are currently allocating 15 full time employees to the program plus senior management staff.

In the New York City metropolitan area, managed care is not yet a predominant product for the small business segment of the economy. Traditionally these employers have relied on indemnity coverage as the only option for their work force. Now, through a joint marketing agreement with Empire Blue Cross and Blue Shield, small employers are provided with the same dual choice of indemnity or HMO coverage that large employers have. This approach meets several objectives including expanded consumer choice and reduced cost to the employer and the employee.

Attachment 1

SMALL BUSINESS PREMIUMS

Monthly Rate	HIP/HMO	Blue Cross Wraparound
Individual	$95.63	$176.50
Family	258.60	409.90
Medicare	30.50	100.50
	No Deductible	$200/500 Deductible

Attachment 2

How can you help stop runaway health care costs from ruining the health of your small business?

Attend an HIP Small Business Open House.

Please join us at one of these valuable and informative sessions. Admission is free. Simply call HIP at *1-800-447-2244* or return the coupon to reserve your place. HIP.

PLEASE JOIN US AT ONE OF OUR OPEN HOUSES.
5:00 P.M.-7:30 P.M.

Wednesday, April 11
HIP Sanford Avenue Center • 140 15 Sanford Ave.
Flushing, New York

Wednesday, April 18
HIP Midland Parkway Center • 180 05 Hillside Ave.
Jamaica, New York

Wednesday, April 25
HIP Astoria Center • 31 75 23rd Street
Astoria, New York

Will attend ☐ Flushing ☐ Jamaica ☐ Astoria Open House
Name_____ Title_____
Company_____
Address_____
City_____ State_____ ZIP_____
Telephone ( )_____
Type of business_____ No. of employees_____
Current health insurance carriers_____
Additional attendees (list)_____
_____

For Further Information Please Contact HIP AT 1-800-447-2244.
Please Respond By April 6, 1990.

HEALTH INSURANCE IN THE SMALL GROUP MARKET -- THE COSE BILL'S PRACTICAL APPROACH TO EXPAND COVERAGE FOR THE UNINSURED

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Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

April 20, 1990

I. The Small Group Health Insurance Market and the Uninsured: Problems and Opportunities

A. Summary. Congress can enact legislation that requires no federal funds, and that will make health insurance affordable and available for the first time to millions of American workers and their families: the Health Policy Coalition's Small Employer Health Insurance Availability and Affordability Act (the "COSE Bill").

B. The Problems

1. "Half of the working uninsured are employees of small firms," Chairman Stark has observed. Specifically, 70% of the uninsured are either employed or dependents of employees, and most of the employees work for small employers. EBRI, "A Profile of the Non-elderly Population Without Health Insurance" 1, 5, 7 (May 1987).

2. There are no federal or state funds available to meaningfully address the uninsured problem.

3. In today's competive environment, employer mandates are really mandatory payroll taxes on employees. The average American worker is now paying 15% of total compensation for health care. (See enclosed chart.)

4. The unavailability of affordable health insurance to small employers is a major reason why there are so many uninsured Americans.

C. The Opportunities

In Cleveland, the Council of Small Enterprises ("COSE") of the Greater Cleveland Growth Association operates a purchasing group that makes health insurance available and affordable to 7,000 small employers and over 120,000 employees and their dependents. Fully 25% of COSE small employers started providing health insurance because COSE made coverage affordable.

The COSE Bill will significantly lower the cost of small employer health insurance through major efficiencies and exemption from non-essential state laws by:

1. Encouraging the formation of private Small Employer Purchasing Groups, like the COSE program in Cleveland. The COSE group purchasing program for small employers "save[s] about 35% over the cost of comparable coverage" for its small employer members. House Committee on Small Business, "The Health Insurance Problem: Alternative Strategies to Expand Coverage Among Small Business," p. 31 (Dec. 1987).

2. Using the Liability and Risk Retention Act of 1986 success in making liability insurance more available and affordable as a model for small employer health insurance. Department of Commerce, Liability Risk Retention Act of 1986 Operations Report (1989) ("1989 Report").

3. Redirecting state premium taxes, which range up to 4%, for newly covered groups, which will not reduce existing state tax revenues.

4. Allowing employers and employees to choose the combination of benefits and costs that best meets their needs by preempting state-mandated benefit laws. In Virginia, mandated benefit laws add 16% to health insurance costs. At least two states, Virginia and Washington, may soon remove their mandated benefit laws for the same purpose. There may be as many as nine million Americans without health insurance solely because of more than 600 state mandated benefit laws. Wall Street Journal, p. B1 (Dec. 28, 1988). None of these laws outweigh the importance of making health insurance affordable to the uninsured.

5. Privately funding reinsurance to reduce pre-existing condition restrictions and high costs for individual companies that experience large losses by charging Group members approximately the amount of the state premium tax.

6. Allow each state to opt out of preemption, if they choose.

II. The Small Employer Health Insurance Availability and Affordability Act ("COSE Bill")

The specific provisions of the COSE Bill are:

1. "Small Employer Purchasing Groups" ("Groups") are defined to be: (a) associations of businesses with less than 500 employees, including the self-employed, that (b) are not established by and are not controlled by an insurance company or any person affiliated with an insurance company doing business with the Group. Groups, like COSE, would be controlled by the buyers, which has been important to COSE's success. Control of purchasing groups by buyers was also recommended for the Risk Retention Act, in the 1989 Report to Congress.

2. Reinsurance Funding. The COSE Bill will help alleviate the problems created by pre-existing condition exclusions by establishing a reinsurance pool funded by (a) savings from mandated benefit law exemption and (b) redirecting state premium taxes for employers that begin providing health insurance. Since these employers currently do not provide insurance, there would be no loss of tax revenues to the states.

3. Incentives for Employers To Begin Health Insurance Coverage. As in the Risk Retention Act, the Group and its insurer would be allowed to substantially lower administrative costs and costs related to health benefits the Group does not consider essential or affordable by being exempted from certain state laws, such as (a) mandated benefits, (b) mandated providers, (c) rate approval (group health insurance rates are rarely, if ever, really regulated), (d) policy forms, and (e) insurance agent and broker licensing (except in the state of the Group's principal place of business).

The substantial claim and administrative savings resulting from these exemptions would be used to (a) subsidize the elimination or reduction of pre-existing condition exclusions, as well as to (b) make health insurance more affordable.

4. State Opt-Out Alternative. Since the exemptions from mandated benefits and other state laws may be controversial, each state would be specifically permitted to pass legislation to opt-out of either or both exemptions.

5. Insurer. The Group's insurer would have to meet certain requirements, similar to some of those found to be appropriate under the Risk Retention Act, such as:

(a) provide a fully or partially insured health plan of any type selected by the Group;

(b) meet federally-set minimum capital and surplus requirements;

(c) declare which state is the insurer's principal place of business, maintain an office in that state, and have members in that state;

(d) provide certain information to regulators in every state in which the Group has members; and

(e) sell only to members of the Group. See 1989 Report.

The COSE Bill deliberately takes a conservative approach to Multiple Employer Trusts ("METs") by not proposing to relax the solvency requirements for Multiple Employer Welfare Arrangements in Section 514(b)(6) of ERISA. See generally Buchman, "Insured and Uninsured METs -- Current Problems," 16 Connecticut L. Rev. 453 (1984).

We suggest, however, that:

(1) easier means be developed for fully-insured METs to invoke the ERISA preemption included in the current law,

(2) practical impediments to insured and uninsured METs under Section 514(b)(6) of ERISA be reviewed,

(3) alternative means of assuring the solvency of METs be considered, and

(4) related issues in the recent 1989 Report on the Liability Risk Retention Act be reviewed.

6. Access to Quality Measurement Data. Groups would specifically be allowed access to the quality measurement data that will be produced under new federal initiatives. Access to this data will materially assist patients, employees and employers to obtain better quality health care at more affordable costs.

7. Annual Notice to Employee of Costs. Employers would notify employees annually in their W-2s or otherwise of the total costs of their Group health insurance, including both the employee and employer paid amounts. Employee access to the total cost of their health insurance will give employees some of the information they need to influence the amount of their compensation that goes to health care, and to help them keep their health insurance affordable.

8. Self-Employed Premium Deduction. The self-employed would be allowed the same 100% deduction of health insurance premiums available to corporations.

9. COBRA and ERISA Reporting. In order to remove ambiguities in the law, and to encourage the formation of Groups, the COSE Bill would (1) make explicit that each employer insured through Groups is responsible for complying with COBRA and ERISA's reporting requirements, and that none of the penalties under those laws apply to a Group; and (2) exempt Groups and employers insured through Groups from pending and future laws that would impose filing fees on ERISA form 5500.

III. Cleveland Health Quality Choice

More fundamentally, a new direction is urgently needed in health care for both the insured and the uninsured. Today the predominant insurance reimbursement system pays for procedures regardless of results and costs. We need to become more efficient and pay for what we do for patients, not for what we do to patients. We must move from a pay-for-service system to a reimbursement system based upon quality, efficiency and results. An example of the new direction that can be taken is Cleveland Health Quality Choice.

Cleveland Health Quality Choice was initiated by ten CEOs of major American organizations -- Ameritrust, BP America, General Electric Lighting Group, LTV Steel, Nestle Enterprises, Ohio Bell, Parker Hannifin, Reliance Electric, Sherwin Williams, and Jones, Day, Reavis & Pogue. These ten CEOs are personally stepping forward to make an effort to reform our health care system.

Beginning with this core company involvement, Cleveland Health Quality Choice will grow into a broad, regional initiative based on three principles:

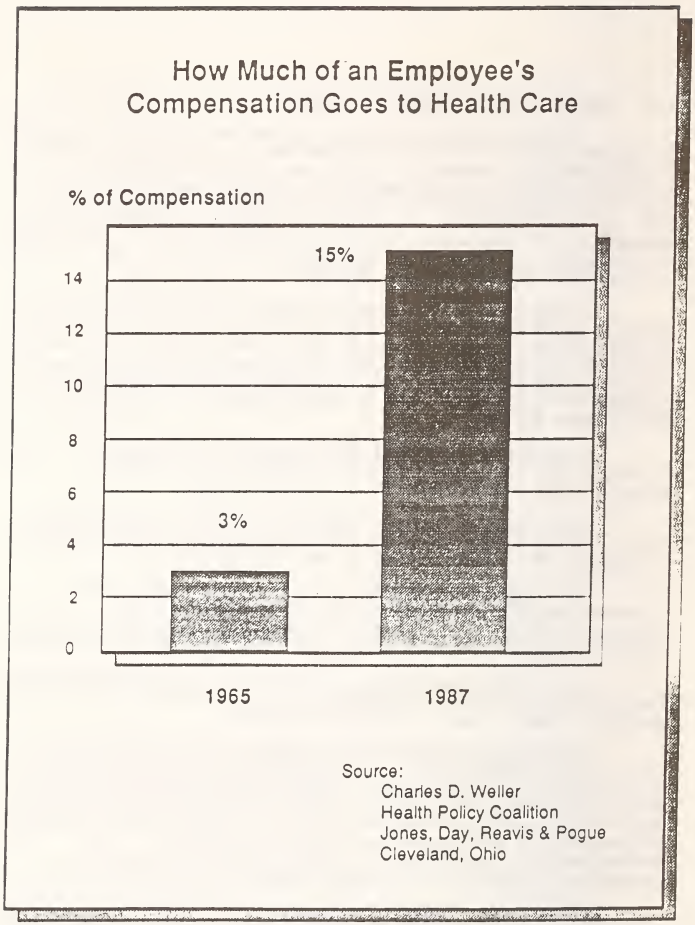
1. Patient Choice. Provide employees and patients with a choice in how much of their compensation and income goes to health care. They presently have little choice.

2. Quality. Improve the measurement of quality outcomes and provide patients and their doctors with information on quality outcomes and medical uncertainty so that patients receive the best value for their health care dollars.

3. Incentive Reform. Change the incentive system for doctors and hospitals so that patient choices on the cost and quality of their health care are rewarded.

Cleveland Health Quality Choice is proceeding on two tracks at the same time. First, employers are implementing, now, health insurance benefit plans that allow employees and their families to choose their health care providers using the best quality/cost information that is available today. Second, to improve the information and feedback process, it is developing in cooperation with local hospitals and doctors a community-wide quality/cost measurement system.

The Health Policy Coalition is willing to work with Congress to develop and implement patient choice alternatives and to pursue the new directions in health care policy we so urgently need. If we can redirect the $150 billion that is wasted annually on unnecessary or ineffective medical care, we can preserve health benefits for the 210 million Americans that currently have them, and improve access for those that do not.


How Much of an Employee's
Compensation Goes to Health Care
% of Compensation
14
12
10
8
6
4
2
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3%
1965
1987
Source:
Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

INSURANCE ASSOCIATION OF CONNECTICUT

STATEMENT
TESTIMONY OF H. CRAIG LEROY
THE BLUE RIBBON COMMISSION ON STATE HEALTH INSURANCE
TUESDAY, JANUARY 9, 1990

The insurance industry is greatly concerned about the near 272,000 Connecticut citizens who do not enjoy the protection of health insurance. The industry has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. Our companies are committed to working with government to implement effective approaches for providing coverage to this population.

Indeed, we need a shared partnership between government, business, insurers, as well as health care providers if we are to step forward in Connecticut and address the issue of the medically uninsured. It is no one's sole responsibility but it is going to take everyone's willingness to do things differently if we are to make progress in Connecticut. As you will hear, the Connecticut insurance industry is willing to answer that challenge. We hope others are also willing.

The task of ensuring that all our citizens enjoy the protection of health insurance is complex. This complexity is largely a function of the diversity of the uninsured population; this diversity requires a combination of private and public solutions.

A positive, multi-faceted approach that addresses the people greatest in need and responds to the different portions of the uninsured population is necessary.

The IAC proposes a 6-point program of public and private sector partnership to respond positively to this challenge:

1. Creation of basic, no-frills insurance policies for the small group market (25 lives and less). These plans would focus on preventative and catastrophic coverages and eliminate or reduce certain mandated benefits. These policies would provide significant premium savings for the purchasing small employer.

2. Tax Credits for small employers who purchase the basic policy for their employees and who pay at least 50% of the premium;

3. Premium tax waiver for these basic policies to further reduce the cost to the policyholder;

4. Legislative study of the efficacy of the basic policy program outlined above after a three-year period so the Legislature can determine whether it works, should be modified or eliminated;

5. Expand the Medicaid program to ensure that all individuals below the poverty line are covered, consider Medicaid "buy-in" and "buy-out" programs, and work to develop demonstration projects targeting maternal and child-care benefits. The IAC and its member companies will be willing to assist in exploring these initiatives with the state;

6. Enhance the stability and accessibility of the small group health insurance market in Connecticut by establishing a statewide reinsurance mechanism and by making fundamental changes in industry practices regarding underwriting and rating.

I will now discuss each of these in more detail.

Expanding Coverage in the Small Employer Market

More has to be done, with efforts from both the public and private sectors, to provide small businesses with the opportunity to purchase affordable health coverage. Nationwide surveys show that two-thirds of the working uninsured are employed in companies with fewer than 25 employees. Also, surveys demonstrate that small businesses do provide health coverage to their workers once they grow or can afford it. Currently, health coverage is unaffordable

to many small employers. This is because the cost of health services continues to increase much more rapidly than overall inflation and the rate of utilization of these services continues to increase. Health insurance premiums must reflect these underlying cost trends.

We believe, however, there are actions that can be taken to provide more affordable health coverage for small employers, incentives that encourage small businesses to buy coverage for the first time, and a more stable market in which to purchase coverage.

More Affordable Coverage is Needed

Underlying affordability problems faced by small employers must be addressed. Currently, Connecticut's mandated benefit laws prevent insurers from offering lower cost benefit plans. The increase in the cost of coverage due to the state's mandated benefit laws is responsible for some businesses choosing not to purchase health coverage. Making affordable coverage available would allow employers and employees the flexibility to decide the type of healthcare they would like to purchase. Furthermore, small employers should be provided the very same freedom from state mandated benefits laws now enjoyed by self-insured plans (which typically are used by larger employers). It is ironic that small employers, those least able to afford health coverage, are saddled with purchasing these costly mandated benefits.

Carriers should be permitted to sell to small employers low-cost benefit plans free of some of Connecticut's mandated benefits. We have developed several low cost prototype "pared-down" plans that could be offered to the small employer community. "Pared-down" coverage should be offered for a limited time to small employers not yet offering coverage as an incentive to have these employers begin offering coverage. A sunset provision and study of the effect of offering such policies should be included in any proposed legislation.

Tax Credits are Needed

We should grant employers who are purchasing a pared-down policy for their employees a tax credit. Pared down policies should also be exempt from the state 2% premium tax with the savings being passed to the policyholder. (This exemption would have little fiscal impact on the state since these would be new policies being sold.) Providing tax credits and a premium tax waiver for the purchase of a pared-down policy could have a significant impact on making health coverage more affordable.

A More Stable and Predictable Marketplace that Guarantees Availability Is Needed

A reinsurance mechanism, coupled with underwriting and rating restrictions for health coverage written in the small employer market, should be established. In the present marketplace, certain small employer groups may present a high or even uninsurable risk due to the presence of high risk individuals or the high risk nature of their business. For many of these businesses, the cost of health coverage is prohibitively expensive. The small employer reinsurance mechanism coupled with reasonable underwriting and rating restrictions would help provide more affordable coverage to small employers.

A not-for-profit reinsurance mechanism should be established and would serve to promote availability. It would allow insurers to "reinsure" high risks with the reinsurance mechanism in exchange for a reinsurance premium. Claims incurred by reinsured risks would be covered by the reinsurer. This would encourage insurers to accept

risks that they might not normally accept since they are protected by the marketplace at large from the costs of accumulating a disproportionate number of high risks.

Employers would pay some or all of the reinsurance premium, depending on the circumstances of reinsurance. However, the process of reinsurance is intended to be invisible to the insureds within the groups in order to avoid discriminatory treatment and protect employee privacy. To accomplish these objectives, an employee will not be aware that he is being reinsured by an insurer. When a carrier has chosen to reinsure, they will continue to pay the claims (and/or utilize the same delivery system) for the nonreinsured and reinsured risks. The processes of reinsurance premium payment and reimbursement for reinsured risks are purely transactions between the carrier and the reinsurer.

Naturally, the reinsurer will incur losses. Insurers will generally only reinsure risks for which they expect the actual claims costs to exceed the premium for reinsurance. Therefore, the losses generated would be spread back equitably across the marketplace. However, to avoid exacerbating the affordability concerns of the small employer market, limitations on the amount of losses are necessary. Legislation creating the mechanism should not require the small business community to pay any pool losses which exceed 5% of the total premium for small business group health insurance in Connecticut. To that end, a premium tax offfset should be provided for participating insurers for any losses exceeding 5%. Otherwise, serious harm could be done to small business due to increased affordability problems.

In addition, reasonable underwriting and rating restrictions would also be imposed on carriers writing in the small employer market in order to provide needed stability to this marketplace. These restrictions include:

-Rate restrictions to eliminate the traumatic rate increases currently levied on some small employers. Medical costs continue to increase rapidly and premium rates will continue to reflect those increases. However, these rate limitations would inject some needed predictability and stability into the small employer market, thereby allowing small employers to plan and budget for health coverage costs with greater ease.

-A prohibition on all carriers from cancelling a small employer's coverage except for fraud, non-payment of premium and the like. Thus, cancelling a group for adverse claims experience would be prohibited.

-A restriction on all carriers on their ability to impose pre-existing condition limitations under certain circumstances.

-A requirement imposed on all carriers to accept or reject entire groups. Employers and insurers could not exclude any individual in the group who wanted coverage.

-A prohibition on all carriers from operating in the small group market unless they operated according to these rules.

The small employer reinsurance mechanism coupled with the underwriting and rating restrictions is intended to serve several goals. First, it would promote the availability of coverage to all small employers, including groups with high risk individuals. The reinsurance mechanism will provide the necessary safety net for those employers and employees who are currently experiencing difficulty obtaining health coverage due to existing medical conditions. Second, the reinsurance mechanism and the rating restrictions would interact to provide a more predictable and stable

pricing structure for small employers, as well as making the coverage more affordable for groups with employees possessing existing serious medical conditions. The rate restrictions will also help alleviate tremendous premium increases some employers are currently experiencing. Lastly, by imposing the underwriting and rating restrictions (both initially and at renewal), small employers will be more fully protected from being cancelled outright or being priced out of the market due to adverse claims experience.

Let me emphasize what I have just described. This proposal would impose significant but reasonable underwriting and rating restrictions on carriers and it would radically change the way carriers operate in the small group market for the better. While these restrictions may increase costs for some groups, we believe it is a necessary response to the problems experienced in the small group market and it should provide a more stable market for small employers, thereby encouraging them to provide coverage to their workers.

Public Assistance for the Uninsured with Low Income

The proper role of government and a priority of any program for the uninsured must be to provide coverage to low income individuals through carefully targeted, improved, and expanded public assistance programs. Eligibility for public assistance programs should be broadened to ensure that all persons who fall below the poverty line are covered for health care services, irrespective of age, disability, family or employment status. If available funds prevent full coverage up to the poverty level, priority should be given to children before other populations. Priority should also be placed on primary care and preventive services. Governmental assistance to the poor and near poor could take several creative forms and could involve public/private cooperative efforts. The suggested forms of public assistance outlined below are just that--suggestions. The IAC, representing major Connecticut insurers, offers the resources of our member companies to help state government examine current Medicaid programs and devise possible expansion. We are also aware of certain budget realities. However, we should jointly begin the process of discussing how Medicaid should evolve to help more low income individuals obtain medical services.

Medicaid Buy-In

Connecticut should evaluate creating a limited Medicaid "buy in" program. Individuals and families with income above the poverty line but below 150 percent of the federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care coverages through the state's Medicaid Program.

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection.

Medicaid Buy-Out

We should also examine creating a Medicaid "buy-out" program.

Medicaid eligibles who are working should be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, state Medicaid programs could be given the option of paying (and receiving federal matching funds which would take federal legislation) the employee's share (if any) of the private insurance premium, as well as other costs. Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage. For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

Such a program would support the current public policy concept of encouraging low-income persons to work by easing the transition from public support to self support.

Health Care Management Initiatives

Controlling health care costs is an important component of maintaining and expanding employer coverage and expanding the number of people covered by public sector plans. Healthcare costs are being driven mainly by a number of factors including demographics, new technology and cost-shifting from the public sector. The private sector is, however, developing and implementing programs aimed at better management of health care costs. The goal of health care cost management is to restrain costs without reducing quality of care.

New and creative provider networks are also being developed to cost efficiently provide care. Both PPOs and HMOs are used for this purpose. New services such as utilization review which introduces an informed buyer into the health care services transaction are being implemented. The health care delivery system continues to evolve in response to concerns about the costs of health care and carriers continue to develop innovative cost management techniques.

Policymakers should encourage development of the private sector's cost-management techniques. Restrictions on the use of these techniques will cause an increase in a currently unaffordable product for many. In addition, the public sector could benefit from aggressively implementing these healthcare cost management techniques in their own health care programs.

Conclusion

I would like to conclude by reemphasizing my initial point. Addressing this issue of providing health insurance for all our citizens is complex. It demands a shared responsibility among government, business, the insurance industry, as well as the health care community. We in the insurance industry have offered today a proposal which would radically change how we do business in the small business health insurance marketplace. Nothing like this has been proposed elsewhere in our country. Yet, it is the responsibility of all involved in the health care system to shoulder part of the responsibility in addressing this issue. As the growth of health care costs continues to skyrocket, the ability of insurers to slow the increase in insurance premiums is limited. Only by working together can we create a solution in Connecticut which can be effective and, of which, we can all be proud.

NFIB

National Federation of
Independent Business

SUBMITTED
STATEMENT OF

THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: House Ways and Means Subcommittee on Health

Subject: Health Insurance Cost and Small Business

Date: April 3, 1990

On behalf of the over 570,000 small business owner members of the National Federation of Independent Business (NFIB), please submit this statement into the hearing record. The NFIB membership comes from all walks of life, reflecting the national small business community in its distribution among standard industrial classification (SIC) codes. That is, NFIB's membership has similar percentages of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exist in the national business profile. This is important with respect to the survey data.

Small business owners are the victims of a two-tiered problem: first, rising health care inflation and second, rising health insurance premiums or the unavailability of insurance. Both have one common element -- cost. Cost restricts the access of small businesses and individuals to the system. Without affordable insurance premiums or affordable health care, access is a moot issue.

The most recent figure on the uninsured claims that 31.8 million individuals are uninsured.(1) The breakdown of this population is illustrative. It suggests that there are distinct subsets within the uninsured population, each requiring different tactical approaches. A focus upon uninsured workers misses substantial portions of the uninsured population: unemployed, low-income, and children.

For small businesses and their employees, access is determined by cost.(2) Cost also explains a recent phenomenon -- the slight decline in the number of small firms offering health insurance as a fringe benefit.(3) Cost prevents new firms from offering health insurance (4) and jeopardizes the continuation of existing health insurance benefits.(5)

The cost of health insurance can be the greatest payroll line-item cost in a small business -- many times exceeding the combined cost of workers compensation and liability insurance.(6) Exacerbating the problem, a majority of small firms pay 100% of the premium cost. These same businesses have little access to managed care or cost-containment measures. In addition, small firms are unable to obtain the benefits of self insurance (7) and therefore must comply with expensive state-mandated benefit laws (8), pay state premium taxes, and shoulder a larger portion of the carrier's administrative expenses.(9)

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The Guardian of
Small Business

Small businesses are reaching the peak of the frustration level.(10) The reluctant call for help comes as a result of the clash between values and reality. Small business owners believe that every American has a right to health care.(11) Small business owners also desire to offer health insurance as a fringe benefit out of both a sense of familial obligation (12) and competitive necessity. (13) However, the reality of 20 to 300% premium increases, a low profit margin (14), struggling regional economies, and restricted cash flow impairs the business' ability to purchase health insurance.(15)

The causes of the cost crisis are numerous and result from not allowing the marketplace to operate efficiently. They can be divided into four generic categories: the reneging of government obligations; government-erected barriers to offering health insurance; medical inflation; and insurance industry practices. These are addressed later in the "Access for Small Business Strategy". Factored into the equation are variables unique to the small business community that make small businesses especially vulnerable to the workings of this disjointed marketplace.

Two thirds of small businesses offer health insurance.(16) In general, these firms tend to be more mature, more profitable, and have more full-time employees than their counterparts that do not offer health insurance. Despite being fairly stable, these small firms experience high initial premiums and higher renewal premiums. Frequently-cited reasons for the high cost of health insurance for small firms include:

- insurer fear of adverse selection
- instability of the firm
- lack of expert help in choosing plans (17)
- little negotiating clout
- strict experience rating
- nature of the small business workforce:
  a) labor intensive
  b) high percentage of part-time employees (18)
  c) high percentage of older workers
  d) high percentage of very young workers
  e) more remedial workers
  f) high turnover
- high administrative costs for the carrier
- insufficient experience data
- absence of preferential treatment afforded to larger firms
- imposition of state premium taxes

For those not offering health insurance, the following factors have been consistently identified as the most common inherent barriers to offering health insurance: (19)

- Cost of premiums or past increases too great
- Insufficient profits
- Insufficient cash flow
- Employee turnover too great
- Too many employees covered elsewhere -- secondary wage earners
- Too many part-time employees
- Too many older employees
- Employees prefer cash compensation
- Too small to receive group "discounts"
- No suitable cost-containment options available (20)

Access for Small Business Strategy

I. Federal Government Obligations. In at least four separate areas, the federal government has avoided express obligations.

1) Medicaid. Medicaid is no longer a safety net for low income individuals. Medicaid should be reformed to ensure that it fully serves its intended population.

2) Medicare. Medicare has had a serious impact upon the operation of the health care marketplace, including the institutionalization of both cost-plus reimbursement and cost-shifting. Medicare must be redesigned in order to maintain its commitment to the elderly and disabled, but also to reduce its impact upon the remaining marketplace.

NFIB does not offer specific recommendations other than to urge legislators to recognize the large, distorting role both federal programs play in the health care marketplace -- over one-third of all U.S. medical expenditures are incurred by these programs.

3) Full deduction of health insurance costs for the self-employed: partnership, sole proprietorship, and S-corporation business owners. Almost one-half of the businesses in this country are considered "self employed", yet they are discriminated against by the federal tax code. The owners of these businesses only receive a 25% deduction for their health insurance premium costs, while their incorporated counterparts receive a full 100%.

It is estimated that 1 in 6 self-employed business owners are uninsured. A full 100% deduction helps to defray the high cost of premiums, sometimes the highest in a carrier's portfolio because of the very small size of these firms, and encourages the provision of health insurance to their employees.

4) COBRA should be repealed as a business obligation. COBRA acts as an important safety net for former employees. However, the obligation should fall to the state or federal governments to allow those individuals to buy in to a government-sponsored employee health insurance plan. Further, COBRA requires employers to remain the primary insurer for Medicare-eligible employees and to cover former employees for up to 29 months who are Medicare "wait-listed." Both provisions are budget-driven policy decisions, enacted with little regard to the impact upon premium costs of small firms.(22)

Consistent with the small business belief in fiscal responsibility, the above reforms require a concentration and prioritization of overall federal effort, rather than an increase in federal spending.

The above "inherent" factors, coupled with the currently fractured marketplace, result in limited availability of health insurance for small business.

NFIB believes that the issues of cost and access are one and indivisible.(21) Universal access to either insurance or medical care hinges upon both being affordable to the purchaser. Reforms cannot focus upon just one aspect of the problem and be successful.

To address the issue of the uninsured, NFIB has developed a strategy to attack the rapidly increasing health insurance premiums charged to small firms. The strategy encompasses the four principal contributors to the current crisis -- the government, health care providers, insurance industry, and the purchaser. It aims at returning the business of insurance to the "law of large numbers" and restoring a competitive marketplace. It is NFIB's position that the cost crisis stems in part from the interplay between severe fragmentation of the marketplace, provider practices, and government-erected barriers.

Analysis of over ten years of data on health insurance and small business has spawned the "Access for Small Business" plan. The strategy represents a combination of both membership-approved policy positions and study-generated suggestions.

The "Access for Small Business" strategy is outlined below. The objectives of the strategy are to improve access through affordable health insurance and cost-effective quality medical care. Brief descriptions are provided when deemed necessary: additional information is available upon request.

II. Removal of Barriers

The insurance marketplace must be leveled to remove the current two-tiered effect. The first step is to close the ERISA loophole that permits self insurance, or in the alternative, to confer upon small firms unable to absorb that risk all of the privileges of self insurance, including a credit for state premium taxes paid and "community-rated" premiums. NFIB believes that the best marketplace is one where all businesses are participating, regardless of size or wealth. Additional changes include:

- o Preemption of state health insurance mandates to permit the offering of "barebones" policies. There is consensus in the business and insurance communities that such mandates significantly increase the cost of health insurance for non-self-insured businesses and create demand pull inflation. "Barebones" policies are appealing to the segment of the business community that is currently unable to offer health insurance. Mandate-free policies immediately lower the cost of health insurance for all non self-insured firms by a minimum of 20%.(23)

- o Preemption of state laws which restrict the formation of HMOs, managed care, and other cost containment mechanisms.

- o Simplification or reinstatement of the following tax code provisions:

  a) Cafeteria plans (IRC sec. 125) and reformation of regulations regarding rollover and employer liability.
  b) VEBAs
  c) METs
  d) Individual line item deduction or refundable tax credit, on the E-Z 1040, for the cost of health insurance premiums. This deduction or credit could be means tested to ensure direct targeting to low-income individuals or families.

The last item was permitted until 1981. The first four items represented viable options to help small firms manage the cost of health insurance, but are now so complex that few small firms are able to employ these options.

III. Cost containment -- hospitals, doctors, and patients.

NFIB believes that reforms in other areas will not be successful until medical inflation is conquered. Attainment of significant cost containment must include, but should not be limited to, the following:

- o Consumer empowerment. Patients must have information on fees, treatments, and physician practices. Until the patient becomes an active and informed participant, the type of medical care will remain a negotiating point only between the provider and the insurance carrier.

- o Return to individual responsibility.(24) The competitive marketplace will not succeed unless the patient behaves like a consumer and believes that he/she has a responsibility to make good health care decisions.

- Data. Outcomes research, provider-developed practice protocols, and hospital ratings are three methods to coalesce and develop information necessary for informed decisionmaking. In addition, such data provide a basis for informed analysis of treatments by providers willing to modify their practices.

- Wellness education. The key to controlling future health care expenditures is to promote healthy behaviors and preventive care.

- Medical malpractice reforms. The protocols discussed above should be admitted as defenses in a medical malpractice suit.

IV. Insurance Industry Reforms

NFIB believes that if the above reforms are implemented, the insurance industry will be forced to operate in accordance with the "law of large numbers," rather than fragmenting the marketplace to the detriment of small business. By re-creating a marketplace where all employees are essentially part of the same pool, interim solutions such as risk pools or reinsurance mechanisms become unnecessary. To facilitate this goal, underwriting reforms must be implemented immediately.

V. Counterproductive Mechanisms

Small business owners are staunchly opposed to any form of mandate. The term "mandate" includes required benefit packages,(25) simple "pay or play" schemes,(26) mandatory risk pools for small firms,(27) triggers, and national health insurance programs.(28)

ENDNOTES

(1) The estimated number of uninsured individuals has ranged from 31 million to 37 million. The number can also be inflated if dependents of workers and/or "underinsured" individuals are added. The concept of "under" insured is subjective.

(2) The NFIB Foundation has conducted three comprehensive health surveys: 1978, 1986, and 1989. In addition, in 1983 and 1986, small business owners were asked to rank order 75 issues from liability insurance to garbage collection to taxes. Health insurance was ranked number one. Surprisingly, health insurance even ranked higher than liability insurance (ranked #2) at a time when the liability insurance crisis was at its peak (1986).

(3) Two thirds of small businesses offer health insurance. Between the first NFIB study (1978) and the second study (1986) the number of small firms offering health insurance increased by 8 percentage points. Between 1986 and 1989, the percentage of small firms declined by less than 2 percentage points. The decline may be within the range of statistical error or may be the indication of a trend. A 1990 follow-up field survey indicates the latter may be operating. These results were confirmed by the ICF study sponsored by the Small Business Administration.

(4) "New" refers to both established and start-up firms. While two distinct groups, they share at least two common characteristics--marginality and very limited cash flow. In addition, new firms have no past experience upon which insurance companies can assess the risk.

(5) In 1989, over 89% of small business respondents cited the cost of health insurance as becoming "prohibitively expensive." In 1990, 19.7% of firms surveyed without health insurance indicated that health insurance was offered at some time in the past.

(6) Between 1987 and 1989, small business health insurance premiums rose from an average of $1942 to an estimated $2646 [Foster & Higgins data].

(7) Over 50% of the business community self insures, and that number has been rapidly increasing since ERISA's passage in the 1970s. Most firms that self insure tend to be large and profitable. Less than 49% of small firms are able to self insure. Self insurance provides at least four benefits: 1) compliance with state mandates is not required; 2) no state premium taxes are assessed; 3) lower administrative costs; and 4) the company has complete flexibility to design the health benefit plan.

(8) There are over 690 state-mandated health insurance benefits requiring coverage for everything from chiropratic care to mental health care to in vitro fertilization to payment for herbal medicine treatments. State health insurance mandates drive up the cost of health insurance for small firms from between 20 to 30%. Larger businesses that can self insure under ERISA are able to avoid these mandates and design their health plans according to their employees' needs, not as defined by the state government. In addition, state health insurance mandates have been shown to increase medical care inflation by creating an artificial demand for services. The Center for Policy Analysis (Dallas, Texas) estimates that twenty-five percent of the uninsured, both businesses and individuals, are the result of the higher costs created by state health insurance mandates.

(9) SBA estimates that large firms receive 95¢ of benefits for every dollar spent, whereas smaller firms receive 60-75¢ of benefits for every dollar spent.

(10) Sixty-one percent of the respondents in 1989 called for government help in reducing the cost of health care and health insurance. Small businesses also supported the imposition of doctor fee structures in Medicare. However, the majority of small firms oppose national health insurance and an overwhelming majority oppose mandates, strongly believing there are market-oriented "fixes".

(11) Sixty-nine percent either agreed or strongly agreed that every American has the right to basic health care regardless of ability to pay.

(12) Health insurance is the second most frequently offered benefit in a small firm. The first benefit offered is paid vacation time.

(13) In today's shrinking labor market, small firms are intensely competing with both large and small businesses for qualified, skilled employees. A less generous fringe benefit package is a competitive disadvantage which neither attracts nor retains good employees.

(14) The median small businesses owner takes out of his/her business less than the median wage and salary worker. About 40% of the 1989 study respondents took out of their business less than $30,000 last year.

(15) Small firms are price sensitive. Of those firms not offering health insurance, 28% said they would offer insurance if premium costs were lowered at least 20%.

(16) To date, the employee-provided health insurance system has been successful. The number of Americans covered by employment-based insurance has risen from 40% in the 1940s to over 80% in 1989.

(17) Small businesses typically engage in "one-stop shopping". One independent insurance agent is used to provide all of the business insurance needs. In addition, there is limited expertise in the small business with respect to benefit design and negotiation. The owner is typically the benefits manager, payroll administer, etc. The average small business owner spends 8 to 10 hours a week on paperwork alone.

(18) Small business owners view full-time employees (defined as working over 25 hours a week) as distinct from part-time employees. The limited connection to the workplace and the part-timers' preference for cash compensation or flex time explain a difference between the benefits offered the two types of employees. This difference has been institutionalized by the insurance industry, which charges higher premiums for part-timers or refuses to cover such employees.

(19) Less than one percent of those not offering health insurance stated that under no condition would health insurance be offered.

(20) Less than 4% use HMOs.

(21) Cost refers to both the cost of health insurance and the cost of medical care.

(22) MANDATE vote: 92% oppose the requirement to provide health insurance to former employees (5% undecided, 3% favor) and 53% favor complete repeal of COBRA (14% undecided, 33% against).

(23) MANDATE vote: 90% of small business owners oppose state-mandated health insurance benefit laws.

(24) The 1989 survey clearly showed that small business owners believe that access to health care or health insurance was a right; however, they strongly believe that it is the individual's obligation to purchase care or insurance, not the employer's responsibility.
(25) MANDATE vote: 89% oppose mandated health benefits (4% undecided, 7% favor).
(26) MANDATE vote: 94% oppose "pay or play" schemes (2% undecided, 4% favor).
(27) MANDATE vote: 60% oppose risk pools (18% undecided, 22% favor).
(28) MANDATE vote: 78% oppose a national health insurance program (6% undecided, 16% favor). This is currently being repolled.